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XUM

Nursing World

THE OLDEST NURSING JOURNAL IN AMERICA—FORMERLY TRAINED NURSE & HOSPITAL REVIEW—FOUNDED IN 1888

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IN THIS ISSUE

COVER: Margaret Elliot Francis was Nursing World's first editor. It was through her imagination and ingenuity that Nursing World became one of the world's leading nursing journals. It was in August of 1888 that Mrs. Sirch (then Miss Francis) launched the first edition of the magazine. Surprisingly, volume 1, number 1, resembles in many ways any current issue of Nursing World; for instance, there were articles dealing with staff relationships in hospitals, the qualities of a good nurse, and special diets for the bedridden patient. Nursing World has endeavored to carry on the great tradition initiated by Mrs. Sirch and will continue to do so.

JANE SECOR

Jane Secor, R.N., author of "The Art of Leadership in Nursing" on page 14, has had a great deal of experience as a nursing leader. She is the director of education at Vassar Brothers Hospital School of Nursing where she took her own training. For three years after graduation Miss Secor worked as an industrial nurse, then served in the Army Nurse Corps overseas, and taught science at Vassar Brothers Hospital School of Nursing. Miss Secor holds a B.A. from Syracuse University and an M.A. from New York University's School of Education.

J. L. BRIDGES

Jean L. Bridges, R.N., is co-author with Robert F. Mahoney, R.N., of "Nurse, I Want to Know" on page 15. Miss Bridges is a graduate of the Children's Hospital School of Nursing, Boston, Mass. She holds a B.A. degree from Colby College, Waterville, Maine, and an M.E. from the University of Minnesota. Miss Bridges is assistant professor of Tuberculosis nursing at Boston University and conducts the student program at Rutland Heights VA Hospital. Mr. Mahoney is a graduate of the McLean Hospital School of Nursing in Waverly, Mass. He has a B.S. and an M.E. from Boston University. Mr. Mahoney is the former assistant chief of nursing education at the Rutland Heights VA Hospital and is now assistant chief of nursing education at the Jamaica Plains VA Hospital in Massachusetts and assistant clinical professor at Boston University's School of Nursing.

R. F. MAHONEY

Harriet Kandler Leach, R.N., wrote "Interaction of Nursing Personnel with Schizophrenic Patients" which appears on page 26. Mrs. Leach wrote the article when she was director of nurses at Lafayette Clinic and associate professor of psychiatric nursing at Wayne State University. The article is an important contribution to the nursing profession—especially the field of psychiatric nursing—for its pertinent conclusions. At present, Mrs. Leach is teaching at South Mississippi Charity Hospital in Laurel, Mississippi. She is a graduate of New Hampshire State Hospital and holds an M.S. from Boston University; formerly, she was director of nurses at the Boston Psychopathic Hospital from 1950 to 1957. Mrs. Leach has contributed to Nursing World many times before.

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An Important Announcement by the Editors

NURSING WORLD

WITH the September, 1960, issue, the editors are accepting the pressing challenge that faces nursing leadership today. This journal will chart a new course. It will become a medium through which nursing leaders will speak and think together. It will become a journal for nursing leaders.

Change is inescapable. Since the beginning of modern nursing, the quality of nursing care has been measured by the capacity of nursing leaders to meet and master evolving circumstances. The capacity of nursing leaders has been gauged, in part, by their ability to adjust to the new and increasing demands made by medical science. The gap between supply of and demand for nurses has widened so rapidly in recent years that two groups have evolved: those experts in nursing we might liken to "management" and those who must accept supervision and direction and who may be recognized as "service."

To bridge this gap with expertness in nursing—that expertness which calls for adequately prepared administrators, supervisors, head nurses, teachers, and consultants—nursing leaders must think better and faster and more wisely than ever before.

It has become obvious to the editors of this journal that there is a need for an independent spokesman to voice the advanced thinking that is required and is being done by nursing leaders. Nursing leaders realize they owe it to themselves, to medical and medical associate groups, and to the people of the nation to continue their study and critical analysis of the problems confronting nursing today—the problem of preparing adequately—and in sufficient numbers—those nurses who direct, supervise, teach, guide, and inspire others.

NURSING WORLD will open its pages to them to discuss these important matters and to further leader-to-leader contact around the country. In every issue, the thorny problems of our times will be scrutinized from many viewpoints; solutions will be approached from many avenues; creative thinking will be sparked; and mutual understanding will be sought.

In the months to come, the journal will bring to its readers, in words and pictures, the latest

MOVES FORWARD

With the September issue, Nursing World will make important editorial changes which will be of great benefit to the nursing profession.

thoughts of nursing leaders as these thoughts apply to nurse relationships with other fields and each other. It will reach out to all parts of the country to render a full account of how nurse educators are preparing nurses to give expertness in clinical nursing; how these experts have made patient care more effective through efficient use of facilities and personnel; budgeting and cost controls; methods and evaluation of procedures and records; how the tools of management as practiced by industry and business are being made more applicable to nursing situations; it will present reports on management of staffing problems; evaluation of personnel performance; the establishment of effective channels of communication that have worked well for others; also, new developments in therapy; new nursing procedures and technics as they apply to the responsible nurse leader. New products, equipment, and supplies will be presented to keep the nursing leader aware of the newest developments for patient welfare.

The journal will reflect the trends in professional activities as well as management duties to help nursing leaders who are taking their proper place in meeting the health demands in these critical times.

NURSING WORLD will keep many of its popular features but new departments to meet today's needs will take priority. Among the new departments will be A Voice for Graduate Nurse Education and Nursing Service at the Management Level, and Labor Relations, as they affect the nurse's role. Among those departments that will be retained are Legal Problems in Nursing, The Dynamics of Human Relationships in Nursing, Current Drug Therapy, News and Interviews, and Book Reviews.

Watch for the Forward Look in nursing. Watch for the September, 1960, issue of

NURSING WORLD

XUM

Letter to the Editor

The Functions of an Independent Magazine

Dear Editor:

Since our talk at the ANA Convention in Miami Beach I have had an urge to write some thoughts on the function of an independent magazine, and particularly about the way in which such a publication serves a professional group. Nursing World *is seventy-two years old this August—a birthday which I am sure you will celebrate quietly and industriously. For your facility as Editor is making* Nursing World *an increasingly effective voice in nursing.*

When the first issue of The Trained Nurse, *"a monthly magazine dedicated to those who minister to the sick and suffering in hospitals and in homes"* was placed in the post office in Buffalo, New York, in August 1888, by its first editor, Margaret Elliot Francis, its publication represented an act of true pioneering. Nursing was a new vocation, communication was slow and sparse, and a woman who would tackle the field of journalism was either especially courageous or foolhardy. In view of the early struggles to produce a professional journal it seems a significant tribute to the maturity of our early leaders that nurses continue to subscribe to and support an independent magazine. Numerous footnotes in the writings of our early leaders cite* The Trained Nurse, *and later* The Trained Nurse and Hospital Review, *as an authoritative source of information.*

Webster defines an independent magazine as "a periodical containing miscellaneous articles, stories, poems, etc. . . . which does not acknowledge an obligation to support a party's candidate under all circumstances." Thus an independent magazine can be said to function quite apart from the official publication of an organized group. The official publication must serve as the spokesman for and the promoter of the beliefs, the policies, and the programs of the organization. Members of a profession as individuals, will differ with, and need to act apart from the organization if the group is to continue as a vital and effective force in society. The independent magazine serves as a medium of communication through which these different views are expressed. An independent magazine, like a wise counsellor, has the duty as well as the privilege to publish, either editorially or as the expressed conviction of an individual nurse, a layman, or a group, constructive criticism of an official policy or program. It is appropriate, of course, for an author to remember, in dissenting, that if one is worthy of being heard he should be able and willing to defend his point of view in such a way that readers are convinced that the dissenting voice should be heard, even if they disagree.

I believe that an independent magazine should present cross section opinion among nurses. Nurses are a disciplined group —not generally highly vocal and literary. Discipline is an essential part of our professional equipment. The very nature of the nursing function in preserving life and promoting health and well being calls for a high degree of self-discipline as well as dedication. But this discipline should not hamper thoughtful expression and critical analysis.

There are important and controversial issues in and about nursing today which must be discussed frankly, if the profession is to grow and fulfill its responsibilities to society. It might be well to include cross section opinion expressed by friends, neutrals, and others.

An independent magazine can test new and fresh ways of presenting traditional material and can publish articles describing new, unusual, and controversial practices. For instance, we hear much discussion of the changing practice of nursing in relation to medicine. But I cannot recall any published information on a practice about which I have heard directly on two occasions in the past ten years. Recently, a friend of mine who is a literate and successful business woman mentioned, rather casually, that she had become acutely ill during the night. She called her physician, a prominent and respected member of his profession. He sent "his nurse" to her home to give her emergency treatment: he instructed the nurse to remain with her for an hour and to report the patient's condition to him by telephone. At the end of the hour there was another telephone conversation to discuss whether the patient should be sent to the hospital immediately or whether she could wait until morning before determining if hospitalization was necessary. I was curious, so I pursued the subject, tactfully (I hope), and learned that this is a standard and accepted practice by this physician and accepted by this patient and others who use his services. This occurred in a city—several years ago I heard directly of a similar practice by the only physician in a small town. Is this, or any number of variations, a more common practice than we think? If so, would it not be useful to have a physician-nurse discussion of the most appropriate ways by which this and other types of cooperative practice can be used to extend emergency health care in a community?

Throughout the seventy-two years of its life, Nursing World, *the first nursing journal, has changed its name three times. This change of name, in a real sense, reflects the history and progress of nursing. As hospitals began expanding, following improvement in care with the increased number of trained nurses, the magazine became* The Trained Nurse and Hospital Review. *Following World War II. as the peoples of the world began to see and experience the skill of the American nurse —when nurses in other countries looked to American nurses for help and for leadership in creating and maintaining a healthy citizenry, when exchange of information and sharing of knowledge and skill became essential—the name was changed to* Nursing World.

I believe we of the editorial advisory board share with you, The Editor, pride in the past record of achievement, and promise for greater service through constant, scholarly attention to fulfilling the role and function of an independent magazine.

My best to you.

Sincerely,

Annie Laurie Crawford

Annie Laurie Crawford, R.N., M. Ed.

*Index Catalogue of the Library of the Surgeon General's Office, Vol. XIV.

NURSING WORLD

REPORTS

Progress and Developments

Rise in Admissions—There has been an important increase in the number of students registering in professional and practical nursing schools. An estimated 71,297 new students were enrolled in nursing programs in 1959 as compared with 68,851 for 1958. Professional nursing programs admitted 47,797 new students, and practical nursing schools enrolled an estimated 23,500 students in 1959. Diploma programs continued to enroll the greatest number of new students, with baccalaureate programs following, and associate degree programs coming last. This information was announced by the NLN's Committee on Careers.

VNA of Brooklyn—The 71st Annual Report of the Visiting Nurse Association of Brooklyn showed that the predominance of its visits were made to persons over 65 years of age and to infants and maternity cases. In addition to home visits, the Brooklyn VNA offers courses entitled Mothers, Parents, and Education for Childbirth. This organization is a voluntary, non-profit group which serves people throughout the borough of Brooklyn.

The Brooklyn VNA reported a sizable deficit in its expenditures for the year 1959. In an attempt to meet the rising cost of living, the Association has had to raise its employees' salaries by 5 per cent. Hence, there will be a corresponding increase in the cost of home visits. The current cost per visit —$4.75 or 50 cents more than the 1959 figure—is based on the actual cost to the agency. Nurses are on duty, Monday through Friday, at the agency's nine district centers from 8:30 a.m. to 4:30 p.m. Visits are made on Saturdays, Sundays and holidays on an emergency basis. Headquarters for the Association is at 138 South Oxford Street, Brooklyn 17, New York.

Reserve Commissions—More credit will be given for educational background in appointing professional nurses to the Army Nurse Corps Reserve, the Army Surgeon General's Office announced. A bachelor of science degree may be substituted for 18 months of appropriate professional nursing experience; a master of science degree for three years of nursing experience; and a Ph.D. or comparable degree for four years of nursing experience, according to Changes 1 to Army Regulations 601-139.

Previously, these degrees could be credited for only one, two and three years of nursing experience respectively. Now the Army will grant a reserve commission as a first lieutenant, for example, if the qualified applicant has either three years of nursing experience, or a bachelor's degree in nursing plus 18 months of nursing experience, or a master's degree with no previous nursing experience.

Applicants for reserve commissions in the Army Nurse Corps may be appointed in the grades of second lieutenant through lieutenant colonel.

The minimum number of years of actual or "equivalent" experience required for these grades is unchanged: less than three years for second lieutenant, three years for first lieutenant, seven years for captain, 14 years for major, and 21 years for lieutenant colonel.

Lieutenant Colonel Cleopatra Avayanou, visiting Greek nurse and dignitary, receives a cup of tea from Second Lieutenant Beverly Fuller, an Army nurse.

P.N. Convention Resolutions—At the 19th Annual Convention of the National Association for Practical Nurse Education, certain resolutions were adopted. Two important resolutions were "to take steps immediately to develop an economic security program" and to ". . . foster the expansion of formal postgraduate programs" for those L.P.N.'s who meet the entrance requirements, and "encourage those licensed practical nurses who meet the entrance requirements of these programs to obtain this additional training and opportunity for advancement."

Nursing Schools Merge—Boston University and the Massachusetts Memorial Hospitals have merged into one educational unit. The merger was made in order to help meet the nation's increasing demands for more and better trained nurses. As a result, the Hospital School will admit no new students under its own program. Forthcoming plans include providing living quarters for approximately 200 nurses, as well as new classrooms and other educational facilities.

Honorary Awards

SNA's Receive Honors—The ANA membership awards were given to three Student Nurse Associations for the greatest percentage increase in membership in 1959 over 1958. The awards were given to Ohio, the District of Columbia and Nevada.

Announcement

Course for Industrial Nurses—New York University Post-Graduate Medical School is offering a course in industrial health for nurses. The course, limited to 50 nurses engaged in industrial nursing, will begin on October 31, 1960. Some of the topics to be covered in

(continued on page 32)

NURSING

AS OTHERS SEE IT

by SHIRLEY HOPE ALPERIN, R.N.

"IN SEEKING a solution to the nursing shortage, isn't it time to consider seriously a virtually untapped resource—'manpower'?" This question is asked the public by author Allen Rankin in his informative article, "*Men* Can Beat the Nurse Shortage," which appeared in the January, 1960, issue of *The Reader's Digest*—condensed from *The Modern Hospital*.

Mr. Rankin disputes the notion that nursing is essentially a feminine profession. He quotes a spokesman for the National League for Nursing's Committee on Careers who comments: "The men who make good nurses are precisely the same kind who make good doctors, teachers, social workers and ministers. . . The best nurses are those who like people genuinely enough to want to devote their lives to helping them when they need help most."

The article reports the success achieved at Valley View Hospital in Ada, Okla., where a male RN was engaged as operating room supervisor when the institution failed to find a qualified woman. According to the administrator, the operating room now functions more competently than ever before. Although the majority of the 11,000 registered male nurses in the nation are working in neuropsychiatric hospitals, a growing number are being hired as surgical nurses and anesthetists in general hospitals.

Men in Public Health Nursing

Author Rankin mentions some of the men serving in various nursing capacities. He describes the duties of public health nurse Burton Bortnicker, a "31-year old six-footer who could be mistaken for a detective." An employee of the Newark, N.J., health department, Mr. Bortnicker checks on the 250 known cases of tuberculosis. His job is to watch for recurrences in former patients, and to hospitalize active cases for treatment and the prevention of further infection. He also counsels underprivileged families of those afflicted, helping them to understand the nature of the disease.

Under the 1955 Bolton Amendment to the Army-Nurses' Act, male nurses may be commissioned to the Army and Air Force reserves with ranks from second lieutenant to captain, reaching the rank of lieutenant colonel or colonel. Such a nurse is Robert M. Stauffer, a first lieutenant in the paratroop reserves who "comes tumbling from the skies with a first-aid kit strapped to his back."

Reader's Digest notes that many men who enter the nursing profession have originally wanted to be doctors. A typical example is Lawrence J. Bradley, currently director of Genesee Hospital in Rochester, New York. Mr. Bradley's hopes for a medical career were shattered at the time of the 1929 stock market crash when he was a junior at the University of Pittsburgh. He went into nursing, later acquiring his master's degree.

Psychiatric Nursing

Recognized in the field of psychiatric nursing is John Gorton, a psychiatric consultant for the National League for Nursing. Another outstanding practitioner is Leonard F. Stevens, chief nurse at the Veterans Administration hospital in St. Cloud, Minn., who after 29 years of nursing has been appointed to an executive post, heretofore held by women. One of the hospital's female nurses (there are 70 plus), declared that "having a man at the head boosts the prestige of nurses in general."

In reporting the varied positions of male R.N.'s, author Rankin encourages employment as bedside staff nurses. "In England," he states, "in two decades, the number of male nurses has increased 1,850 percent. The United States could well follow her example."

An Act of Heroism

"I Only Did What I Could," a gripping story about a nurse's gallantry in time of disaster was presented in the March, 1960, issue of *Reader's Digest*. Condensed from the *Christian Herald* article by Paul Friggens, it depicts the heroic action of 31-year-old Mildred Greene, a Billings, Montana, housewife, whose superb nursing skill helped to save many lives following last summer's earthquake in the Yellowstone Park region.

Writer Friggens reports that there were over 150 vacation-campers in the area where the earthquake struck just before midnight on August 17, 1959. Mrs. Greene, her husband Ray and their nine-year old son, Steven, had fortunately been spared from injury save for some minor cuts and bruises. After they had placed Steven in their station wagon, ordering him to "be brave" and to remain there until their return, the Greenes started out to help the injured. For Mildred Greene who had not practiced nursing in nine years, this was the beginning of a 15-hour tour of duty.

Her first patient was Mrs. Myrtle Painter, a woman from Ogden, Utah, who suffered a crushed chest and one arm nearly severed in two places. "She [Mildred] stanched the terrible bleeding and bound Mrs. Painter's gaping wounds," states Mr. Friggens. "Then she gave her aspirin and tried to make her comfortable in a trailer. . . Next she treated the husband, Ray Painter, whose leg had been pinned under a fallen tree and who was also suffering from shock and loss of blood." While Nurse Greene was giving emergency care, her husband had organized a "bandage brigade" with a dozen of the campers, tearing up sheets, towels and whatever cloth they could find.

In the meantime, the article continues, word had come through that Hebgen Dam had run over. The next step for the frantic victims was to find high ground at a safe ridge five miles up the canyon. "The exodus began," grimly relates the author. "Ray carried

(continued on page 32)

The story of the spirit that helped to revolutionize nursing. Much of the credit must be awarded to the moving force behind this spirit, NURSING WORLD's first editor—a pioneer in nursing journalism.

Margaret Elliot Francis Sirch

by VIRGINIA A. TURNER, R.N.

THIS MONTH, NURSING WORLD's 72nd birthday, is a time for reflection—a time to reflect upon the growth of the nursing profession as recorded in nursing's oldest journal. It is a time to pay tribute to its founder—a nurse who helped to shape twentieth century nursing, because the influence of her work will be implicit in the work still to come.

From the days when nursing journalism was only an idea in the minds of an enlightened few comes the story of a far-sighted nurse—a nurse who walked hospital floors made of stone and through wards so crowded that beds had to be placed down the center—a nurse who climbed stairs all day because there were no elevators between floors—a nurse who balanced the sad against the comic—a nurse who had virtually no access to information about her profession, because there was no medium through which she could read about new medical and nursing practices. There was no way for her to share her views with colleagues throughout the country.

But one April morning, in 1888, this nurse's voice was heard. The imagination and persuasive power displayed by Margaret Elliot Francis (Sirch) that morning were soon to help change the patterns of nursing and play a large part in establishing organized nursing.

With no means except that of the earnest purpose to do her work well and to satisfy the needs of others, she prevailed upon Alfred E. Rose, the publisher who launched the now historic advertising character "Sunny Jim," secured financial assistance and founded *The Trained Nurse* magazine; her "brainchild" was born, named, and nurtured in Buffalo, New York. Thus, she added to an already heavy schedule as superintendent of nurses a new task—that of establishing and editing the first permanent nursing magazine in the United States, *The Trained Nurse* (now NURSING WORLD).

At that time, there was no post-graduate education for nurses and there was no established legislation to safeguard the practice of nurses and to protect the welfare of patients.

Nurses had no way of communicating

Sophie Palmer
Editor 1895

Charlotte A. Aiken
Editor 1908-1923

Meta R. Pennock
Managing Editor 1921-1928
Editor 1928-1941

with their schools or with each other, because there were no radios, no automobiles, and no airplanes. The telephone and steamships, even running water and bath tubs, were luxuries confined to a very small group of privileged people and used sparingly by those who had access to them. There were just 94 training schools in the United States. *The Trained Nurse* provided the missing link of nursing communication between distant schools. And it was this need for keeping abreast of advances in the field that Miss Francis (later Mrs. Sirch) established a magazine that would be national in scope.

With the help of her co-workers and maturer students, she assembled pertinent material throughout the summer and published the first issue 72 years ago—August 1888.

A Notable First Issue

She gave us in that first issue articles on "Nursing As A Profession For Women," written by none other than Her Royal Highness Princess Christian; "Hints For Nurses," by Miss Jessie McVean of The New York Training School; "Glimpses Of Hospital Life As Seen By The Nurses," by Mrs. Lystra Gretter who, Mrs. Sirch said, "was too retiring to sign her name"; "A System Of Free Nursing As Organized In Philadelphia," written by Dr. Joseph Price; and "Notes On Fever Nursing," written by the editor herself. There are no pictures in that first issue; a pencil portrait of Florence Nightingale appears as the only illustration. The cover, quaint and simple, was of heavy brown linen.

What comes through the pages of the early issues of *The Trained Nurse* is a vivid personality. One feels it on every page. This personality was a blend of courage, devotion, and a stubborness of conviction. Headlong admiration for work well done, unflinching courage in backing it—that was Margaret Elliot Francis. Her editorial philosophy was simple and her creed noble. She states in that first issue the magazine's philosophy: "We mean to be a help, a guide, an inspiration, an encouragement. . . ."

To recognize, to encourage, and to guide nurses in the art of self-expression was, to her, the way to carry out this philosophy. This was a task worth any amount of effort, and nothing, throughout her editorship, swerved her from that allegiance.

Her creed as an editor was the same as it is today: to open the pages of *The Trained Nurse* to any honest viewpoint, worthy of presentation, to give it a chance to take its place in the free world of nursing thought. She had no desire to influence the decisions of her readers, but she did attempt to organize and crystallize their thoughts and ideas. This, she believed, was an important function of an editor.

In 1889, because of ill health, Miss Francis had to resign the editorship. But her work was carried forward by other capable editors.

Need for Unity

In 1893, nurses saw the need for getting together, to think together, and to develop responsible leadership. *The Trained Nurse* began to fill its pages with the exciting news of the first general get-together of nurses, whose purpose was to explore the possibilities of achieving national unity. On June 13, 1893, more than 200 nurses assembled in Hall 26 of the World's Fair Building, Chicago, Illinois. Here the famous decision was made that marked a milestone in nursing history. With Isabel Hampton presiding, discussions were held on important timely subjects such as:

1) Hospitals should control nursing schools, which were originally independent.

2) District nurses should organize.

3) An eight-hour day for students; college preparation for teachers.

4) Nursing schools should be approved only in large general hospitals.

But this pioneering spirit was not confined to those who journeyed to Chicago. As a result of this westward move, thousands upon thousands of nurses joined the crusade. This spirit was reflected in their initiative, and bravery; and in their confidence, they assumed the responsibility for shaping the destiny of nurses and nursing.

The editorial pages of *The Trained Nurse* recorded the temperature, pulse, and respiration of the nursing profession—its hopes and its achievements. *The Trained Nurse* was the only magazine serving the nursing profession until 1900, when *The American Journal of Nurisng* was born.

At the close of 1893, *The Trained Nurse* absorbed the magazine called *Hospital Review*, and for the first few editions it was included as part of *The Trained Nurse*, hence the derivation of the name *The Trained Nurse and Hospital Review*.

With each issue, the magazine expanded its coverage. The nursing public knew, read and loved *The Trained Nurse and Hospital Review*. In 1895, the magazine's editorship was transferred to the capable hands of Sophie Palmer (who later became the first editor of *The American Journal of Nursing*). Because nurses were accustomed to meeting their problems individually, the magazine pressed hard to bring about group solidarity. It was Lavinia Dock, the great nursing leader, who recommended in each issue articles that stressed the need for nurses to unite together in one solid group. Gradually, through suggestions which appeared in the pages devoted to *Letters to the Edi-*

tor and because of the growing demand for a national body, the American Nurses Association was formed and sprung its roots deeply into the nursing profession, to flourish as the official association of American nurses.

Janet Geister
Editor 1940-1946

The following few years the editorial staff of *The Trained Nurse* published such timely articles as "Working Hours," by Adelaide Nutting; "State Legislation for Nurse Protection"; "Official Registries," by Lavinia Dock (who became temporary editor during an illness of Sophie Palmer); and also, on the lighter side, an item on "etiquette" by Isabel H. Robb.

The Spanish American War afforded much mental nourishment about war nursing, and the editor, Annette Sumner Rose, featured stories in the magazine about the Army and Navy Nurse Corps—just seedlings at that time.

Turn-of-the Century Changes

At the turn of the century, the pioneer publication, still under the editorship of Annette Sumner Rose, had absorbed five nursing journals. *The Nightingale*, which appeared in 1886 as the first nursing journal in America, was absorbed first. It was from this journal that the plan originated in the mind of Margaret Elliot Francis in Buffalo, New York, the birthplace of *The Trained Nurse*. In January, 1889, *The Journal of Practical Nursing* (Rockford) was assimilated, and shortly after in 1892, *The Nurse* (Boston) merged with *The Trained Nurse*. *The Nursing World* (Providence, R. I.) and the *Nursing Record* were united with *The Trained Nurse* later. During the twentieth century *The Nurse* (Jamestown) and *The Southern Registered Nurse* were also added.

In 1908, Charlotte Aikens became the editor. She worked fervently to help improve the nursing conditions in hospitals and stressed this importance to her helpful associates of the AHA. This movement "served to sustain professional morale" in those low years.

During World War I, *The Trained Nurse and Hospital Review* kept the nursing home front covered on the latest developments on the Army and Navy Nurse Corps, which had grown considerably since 1900. *The Trained Nurse and Hospital Review* kept homesick nurses on the war fronts informed about what was happening back home.

Rapid Growth of Nursing

The end of the war brought with it problems of broken bodies and minds, gas-infected lungs, and crowded communities in dire need of housing facilities. The public health field developed rapidly. A frequent contributor was Anne Goodrich, who presented the latest facts on community health problems.

The period up until 1929 was one of rehabilitation, world-wide explorations for knowledge on health problems in other lands. Articles on nursing in Labrador, India, Russia, and other countries, brought other parts of the world to the readers of *The Trained Nurse and Hospital Review*. The school nurses had united, and this field was covered by the magazine. Dr. Joslin introduced insulin and his new therapy for diabetics. The magazine published timely articles on this important scientific development.

The recovery era—again the public, nurses and doctors started on a new trend. *The Trained Nurse and Hospital Review* published in each issue the latest news on how these groups were coping with the problems.

When the news of Pearl Harbor rocked the country *The Trained Nurse and Hospital Review* again filled its pages with the new developments in Army and Navy nursing. Flight nursing was a new step in the field. Battlefield nursing techniques were demonstrated by nurses in the nurse corps; warm and cheerful editorials written by Janet Geister boosted the morale of nurses on the war and home fronts. Private duty nurses decided on the new working hours for hospital and home nursing; hospitals elected to adopt nurses' aides, a blessing to the few homefront nurses left in hospitals.

When the war was over, 1945 was greeted by *The Trained Nurse and Hospital Review* with an affectionate tribute to all of those who fought and lost their lives in World War II. Sober obituaries showed long lists of gallant nurses who had served their country. There were pictures and stories for those honored by the United States and for those who served their country faithfully. The nursing profession was justly proud of its war contributions, and this was ably expressed by the editor, Mrs. Ann Walker.

Progress and Change

During and following the war years to 1949, rehabilitation was again in the forefront. Post-war plans for meeting the increased demands and plans for the reorganization of the new status of nurses were covered monthly by the magazine.

The magazine has kept pace with the transition of nursing from a vocation to a profession. In July 1950, because nurses were no longer merely trained, but educated professional women, the name *Trained Nurse and Hospital Review* was changed to NURSING WORLD. The next year, June 1951, *Industrial Nursing* joined the list of journals that had united with *The Trained Nurse*.

Following in the footsteps of its predecessor, NURSING WORLD is not the official organ of any association. It is the belief of the magazine today that issues of importance must be viewed and understood from several standpoints. Although it is an independent magazine, its informational content is professional and authoritative.

As shown by its front page, NURSING WORLD has an editorial advisory board composed of nurses who represent health agencies, hospitals, hospital schools, and colleges of nursing all over America. They are experts in their respective fields, and under their guidance the magazine maintains the highest standards in reporting the dynamic changes now taking place in nursing and in presenting interpretations of the important developments in the nursing profession.

True to its beginning in 1888, its aim is to encourage self-expression on the part of nurses, because it is the nurse who must possess firsthand information about her profession. And it is through the exchange of ideas and knowledge that nurses will be kept informed of the progress that is being made in all areas of nursing.

As stated by its founder, Margaret Elliot Francis Sirch, NURSING WORLD restates its purpose "to be a help, a guide, an inspiration. . . ." Although separated from its editorial offices by thousands of miles, she maintained a lively interest in the magazine until her death in August 1956—at the age of 91—ironically also the month the magazine was born. One can go back to the pages of *The Trained Nurse* to read the history made by this great woman, but not now to her. Time has a value.

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Through the skillful utilization and manipulation of her fund of knowledge, the nurse can adjust basic principles of health and illness to conform to the needs of the individual patient.

THE ART OF LEADERSHIP IN NURSING

by JANE SECOR, R.N., M.A.

Director of Education, Vassar Brothers Hospital School of Nursing, Poughkeepsie, N.Y.

THE aspects of leadership in nursing have been explored and the need for more leaders has been identified; however, the privilege and responsibility of leadership is not reserved for those only in administrative and supervisory positions. The efforts and achievements of those who act as nursing and health team leaders, head nurses, and supervisors are relatively ineffective in terms of the major goals of nursing if there is not effective leadership in the immediate nursing care of the patient or in the immediate health supervision of the well individual.

Any person attempting to direct the activities and attitudes of others is acting in a leadership role. All nursing is akin to leadership. The nurse, in caring for the well and the ill individual, plays many interrelated roles. She acts as counselor, teacher, minister of physical care, interpreter, and coordinator. Through skillful utilization and manipulation of her fund of knowledge, she is able to modify and adjust basic principles of health and illness so that her nursing plan is designed for each individual. The willingness and ability to function with confidence in the face of continual change demands sensitivity, ability to think abstractly and to maintain emotional stability—all qualities of leadership.

It is worth noting that the leadership role, in direct patient-nurse relationships, shifts between the patient and the nurse. The nurse accepts the leadership of the patient when she seeks information from him. She then makes judgments and thus assumes her role as leader. This reciprocal arrangement is possible only when the leadership is democratic rather than authoritarian. All types of control cause hostility. Even democratic leadership is not always accepted without a struggle. Communicating freely is indispensable for overcoming the resistive antagonism which is a common reaction to authority. Ability to communicate allows the leader to share ideas which can lead to action. The art of communicating, actively and passively, is a vital requisite for leadership.

The Role of Discipline

Effective health care necessitates the enforcement of discipline. This discipline involves altering or restricting actions and attitudes, which affect both the patient and the nurse. The nurse who is self-confident, sincerely fond of people, skilled in solving problems through creative action, sensitive to the needs and reactions of others, well-informed in her area of responsibility, and able to communicate effectively can more easily elicit the cooperation of the patient. One readily sees that these qualities are essential to good nursing; but closer examination reveals that these are also qualities necessary for productive leadership.

More challenging, indeed, is the leadership required for the nursing care of persons widely differing in age. The care of the newborn and the infant requires complete authoritarian leadership rendered with tenderness and love; the child requires a modified authoritarian leadership which encourages freedom of emotional expression; the young adult requires cautious and subtle leadership primarily aimed at achieving cooperation and acceptance; the adult deserves recognition of his ability to participate, within his limitations, in the directing of his own health environment; the senior adult needs the freedom of self-assertion mellowed with the comfort of readily available assistance. The nurse who can manage patients of different ages and who can maintain control over each situation is, truly, a flexible and capable leader.

Leadership ability is of equal importance in both of the broad areas of nursing—supervision of health maintenance and care of the ill. In each of these areas, successful leadership becomes allied with salesmanship. As a salesman, the nurse participates in the various phases of selling which include the identification of goals, definition of problems to be solved, implementation of a plan of action, and devising means for measuring the benefits derived from the plan. Each new situation presents the nurse with challenges. The degree of acceptance of the goals are affected by the nurse's salesmanship talents.

Leadership involving only one other person demands application of all of the skills required for group leadership. Unlike group leadership, however, individual leadership allows little room for failure. Larger groups may have opportunities for selecting an alternate action if the original course is unsuccessful. This is not always possible in the immediate patient-nurse situation where time is valuable and progress is vital. Effective leadership in nursing the individual contributes to the productivity of larger groups whose efforts, in turn, are directed toward preserving the health of the individual and providing for optimum care of the patient.

Successful leadership in professional organizations such as the hospital, public health or school health administration, cannot be attained without fruitful leadership at the core, between the nurse and the individual.

Leadership is an essential part of all undertakings in which the nurse is involved. The heart of nursing is the art of leadership. Through effective leadership, the nurse is a successful salesman of life's most precious commodity—health.

When the tuberculous patient asks the nurse for information concerning his condition, she must be prepared to give him an answer. To determine how well nursing students function in this situation, a study was conducted.

"NURSE, I Want to Know!"

by **JEAN L. BRIDGES, R.N., B.A., Ed. M.**
Assistant Professor, Boston University School of Nursing

and **ROBERT F. MAHONEY, R.N., B.S.N., Ed.M.**
Assistant Chief, Nursing Education, Rutland Heights, Mass., V.A. Hospital; Assistant Clinical Professor, Boston University School of Nursing

WHEN A patient asks a question, it must be answered. How well the student nurse answers and/or wisely refers patient's question to another member of the health team is of vital importance. Not only answering questions but patient teaching, in general, is also an essential part of nursing care, particularly for patients with long-term illness who have special needs for knowing about their disease. This is especially true in tuberculosis because of its communicability, the long period of hospitalization necessary and the effect of drugs on the patient's feeling of well-being.

To determine how well the student functions in this situation, a survey was conducted by Boston University with six other collegiate schools of nursing* participating. Using the clinical facilities of the Veterans Administration Hospital at Rutland Heights, Massachusetts, students in the Boston University program in tuberculosis nursing participated in this survey.

The director of the program is a full-time member of the Boston University faculty. A second full-time instructor is assigned to the program, providing a ratio of one instructor to ten students. The Veterans Administration Hospital primarily cares for patients with tuberculosis and has 400 beds for this purpose.

During this experience each student is assigned to a ward, going to other areas of the hospital for only selected learning experiences. She gives care to the same two patients throughout the learning experience, being responsible for their nursing care plans and ward conferences. However, she may give care to added patients for specific reasons.

In addition to informal teaching, which is a part of all nursing care, students participate in two formal teaching experiences. One of these is individual teaching of the new patient in an interview-type situation; the other consists of conducting group classes with new patients following the interviews.

The individual teaching interview is designed to provide information helpful to the patient as soon as he is admitted. The content is based on such factors as what he already knows from pre-hospital teaching or previous admissions, his immediate problems, his need for orientation to the hospital and its services, and his degree of illness. Constant in all of these interviews is the need to introduce to, or review with the patient the necessity for rest, the principles of asepsis, the use of tissues, sputum box, and the protection of staff and visitors.

The group orientation classes include sessions on (a) structure and function of the lungs, serving as a basis for understanding terminology; (b) general discussion of treatment designed to give information from which patients can personalize questions to their doctors; (c) a discussion, by the physician, of basic disease and simple pathogenesis; discussions designed to orient the patient to (d) social services; (e) rehabilitation; (f) vocational counseling services; (g) demonstration of laboratory examinations; (h) showing and discussing the National Tuberculosis Asso-

* Boston College, Radcliffe-Massachusetts General Hospital Nursing Program, Simmons, St. Anselm's, N.H., University of Massachusetts and University of Vermont.

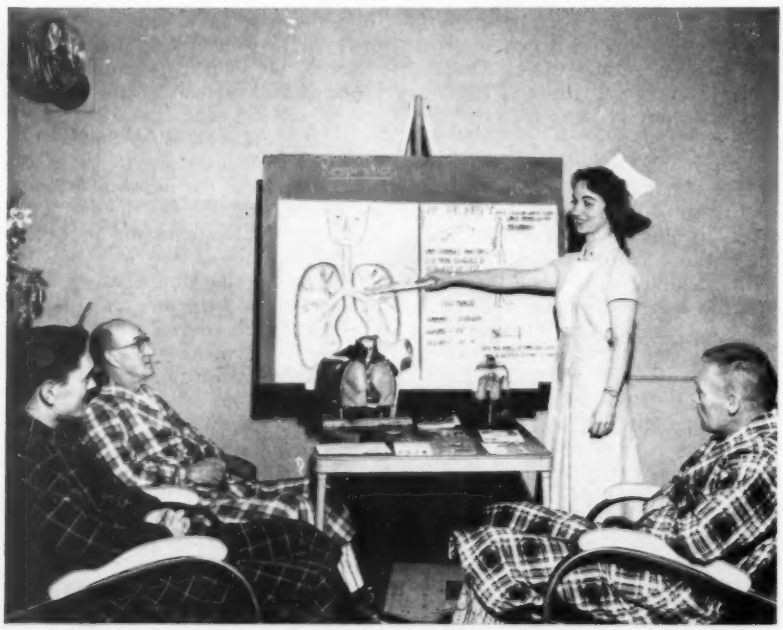
Miss Ida Knapp, student at Boston University's School of Nursing reviews the great importance of asepsis with Tuberculosis patient Emilien La Fontaine.

ciation film, "The Inside Story."

Students conduct the first two sessions and discuss the film. With the help of representatives of other departments, they may lead other discussions. Follow up of each session with their own patients is each student's responsibility. Students are given assistance with planning both individual and group discussions.

The first week of the student's experience is primarily used for classes and observations with little assigned patient care. A class discussing the patient-teaching program is included in this first week.

Patients William Dailey, Leavitt Parent and John Munro (left to right) are given an important lecture on their disease from Margaret Rasche, a student.



The specific objectives of the survey were:

1. To find out the questions that patients ask nursing students.
2. To determine the value of the first week's course content in helping the student to answer these questions.
3. To assess the quality of the answer in the beginning weeks as against the final weeks of the student's experience.

It was obvious early in the survey that objective number three could not be determined because of the time of the teaching assignments. Most individual teaching came early in the experience, most group teaching near the end, and comparisons were therefore not valid.

The survey covered a period of one year, during which students were requested to submit questions and their answers. With all duplicate questions removed, a total of 120 different questions were submitted on three-by-five cards. The information requested included the patient's questions, the answer given by the student, whether the question was asked in an informal or a formal teaching situation, the student's class year, clinical areas studied before this one, the college and the week of the experience here. Only the question, the answer, and the formal-informal information have been used.

A New Factor

An unlooked for factor has been the observation that some questions are asked primarily to "test" the student. It would appear that later questions are often dependent on how she handles these "test" questions. Some questions are asked to compare the answers with those given by other members of the health team or even previous students.

Of the 120 different questions 44.1% were the result of a formal teaching situation and 55.9% the result of an informal situation. The questions were classified into four broad categories and a miscellaneous category. The category, the number of questions and samples are as follows:

1. Basic Disease (15)
   A shadow on the lung isn't really bad, is it?
   I came here because of fluid in my lung. Where did it come from?
   Can you get Tuberculosis in any part of your body other than the lungs?
2. Epidemiological Aspects (30)
   Why do the nurses wear the costumes? (cap, mask, gown)
   Tuberculosis runs in families, so why isn't it hereditary?
   Can we catch Tuberculosis from

other patients?
Why did I have three negative tuberculin tests and then have a positive while in the hospital?
My children were tuberculin tested when I was found to have Tuberculosis. Their tests were negative. Why won't x-rays be taken of them?

3. Medical-Surgical Management (53)
How long do you have to stay in the hospital?
What actually do the drugs do? Why take two kinds?
My sputum culture has been positive, yet the smear was negative. Does this mean the disease is still present in my lungs?
What are these tubes doing?

4. Rehabilitation (19)
Is it possible to bowl and swim and participate in other sports even if you have Tuberculosis?
In what way could social service help me?
I'm in Class II. What does this mean?

5. Miscellaneous (3)
All questions related to structure and function of the respiratory system.

One hundred and twenty different questions asked student nurses by patients in a 400-bed tuberculosis unit (VAH, Rutland Heights) during the year 1959 and categorized as follows:

I. *Basic Disease*

1. I am gaining weight fast now. I guess that means I am getting well, doesn't it?
2. Why does my temperature go up every afternoon?
3. Is TB caused by bronchitis?
4. How much do you know about tuberculosis? Is it possible to have it spread to the bronchial tubes? Can it be treated there? I think that mine has spread to there. What do the tubes look like, anyway?
5. How do you get tuberculosis of the kidney?
6. How does infection spread from one lung to another?
7. What is the difference between hard and soft tuberculosis?
8. Can you get tuberculosis in any part of your body other than your lungs?
9. I came here because of fluid in my lung. Where did it come from?
10. A shadow on the lung isn't really bad, is it?
11. Is tuberculosis of glands same as tuberculosis of lungs? (Patient meant if they were caused by the same organism)
12. Does smoking have a bad effect on tuberculosis?
13. If an arrested case cannot contract tuberculosis from another patient, why can he leave the hospital and return with reactivated tuberculosis?
14. What is soft disease?
15. If any change in cavity, do you have active tuberculosis?

II. *Epidemiological Aspects*

1. Tuberculosis runs in families, so why isn't it hereditary?
2. Why do the nurses wear the costumes? (meaning cap, mask, and gown)
3. What have you got on all that "rigmarole" for?
4. My children were tuberculin tested when I was found to have tuberculosis. Their tests were negative. Why won't x-rays be taken on them?
5. If I am chiefly responsible for my treatment why is it necessary for me to come to the hospital?
6. What is the meaning of a tuberculin test?
7. Why do I have a negative tuberculin test with a positive sputum test?
8. Why do they put patients with positive sputum in the same room with patients with negative sputum?
9. Why don't they separate 2 and 4 tag patients? Won't the 2 tag reinfect the 4 tag patients?
10. Why can you definitely have tuberculous disease and still have a negative tuberculin test?
11. Doesn't red area on tuberculin test mean you have active disease?
12. What is BCG?
13. Isn't it true that everyone has tuberculosis germs in their body?
14. Why do you have to kill tuberculous cows if milk is to be pasteurized?
15. If you have a run down condition won't this cause tuberculosis even though you don't have the organism?
16. What is the best way to get tuberculosis?
17. Can children catch tuberculosis from their parents?
18. I don't understand what you mean by contact?
19. Can tuberculosis be cured?
20. Why did I have three negative tuberculin tests and then have a positive while in the hospital?
21. Can we catch it from other patients?
22. What does a positive tuberculin test mean and the value of BCG?
23. I have been living with my wife. How come she didn't get tuberculosis?
24. Isn't everyone born with the bug?
25. I don't know how I got it . . .
26. My nephew had a positive tuberculin, does this mean I got tuberculosis from him?
27. They don't know yet if I have tuberculosis, won't I stand a good chance of getting it?
28. Why do I need three tissues when I cough?
29. Why shouldn't you shake your pillows and puff them up?
30. Why do you have your watch all wrapped up in paper?

III. *Medical and Surgical Management*

1. If one is receiving drugs for six months on the outside of the hospital, will this cut down his hospital stay?
2. Is there less chance of recovery from surgery in the older patient?
3. When a lesion shows up on x-ray film, why can't surgery be done immediately?
4. How many ribs can be removed before causing any deformity?
5. How many balls do you need to collapse the lung?
6. If I have cavity on each lung how long will they wait between two operations?
7. Is it dangerous to have surgery done on both lungs?
8. How long do you have to stay in the hospital?
9. Do they ever remove the "balls" after they have been inserted?
10. Patient wanted to know if spheres dissolved after a while?
11. Why do I have to take both PAS and INH especially since PAS is a weak drug against tuberculosis?
12. Why do some patients get streptomycin twice a week and others every day?
13. What actually do these drugs do? Why take two kinds?
14. What are my pills for?
15. What does it mean to be sensitive to Streptomycin? I got a rash, itched and now I don't get it any more.
16. I've been taking these drugs for two years and I'm still here so what good are they doing me?
17. After talking about removal of spheres, a patient wanted to know if he would have his removed.
18. Do they put balls in the lungs?
19. What is a tomogram?
20. What is pneumonia and how

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can it be differentiated from tuberculosis on x-ray?

21. Why do they have sanitoriums in the mountains, where the altitude is higher, therefore less O_2, and the lungs have to work twice as hard to get O_2?
22. Can you take INH and Streptomycin together?
23. Can you take PAS by itself?
24. What is the new drug that is in New York that cures tuberculosis but they do not know what it will do to the body in six years, like cause paralysis, blindness, deafness, etc.?
25. Why do some patients not have any drugs?
26. How can tuberculosis medicine help the lung if it goes directly to the stomach and never goes to the lung?
27. When they test for drug resistance, how is it done? Is it done on the patient?
28. If you are not receiving drugs, does it mean you're getting better?
29. Do the new drugs kill the tuberculosis germ?
30. My sputum culture has been positive yet the smear was negative. Does this mean that the disease is still present in the lung?
31. They want me to have surgery but I don't have a cavity and they can't promise I won't get more tuberculosis or that the operation will be successful. What's the sense of it?
32. What are these tubes doing?
33. How long does it take for x-ray films to be developed?
34. Why are they taking so many blood tests on me?
35. What is a stereo? Why do they want to do it on me?
36. Can you have a "hot" culture without having tuberculosis?
37. Is it true that a patient has to have a total of six negative sputums before he can be discharged?
38. Will I really have to remain here for a couple months?
39. They say that every case of tuberculosis is different. Why then are they all treated the same way?
40. Why do I get pills once a day and why do I get different medicine from the other fellows?
41. Tell me—what exactly is the action of my medication, the PAS and INH?
42. Where does streptomycin come from, does it come from a mushroom?
43. Can a person become deaf from using too much streptomycin?
44. I wonder why I don't get cortisone any more?
45. Why aren't drugs used at the same time in all hospitals?
46. I have heard that many patients get sick from the drugs. I am taking three different drugs. If I get a reaction from one—how will they know which one to stop?
47. Does PAS just help the other drugs to work better?
48. Will all the medications I am taking make me sterile?
49. That new drug that I was reading about that was discovered in Sweden, why don't they use that here?
50. Is this the newest drug against tuberculosis? Which is the best?
51. Why is there so much talk about vitamin B? What makes it more important than the others?
52. What is the difference between V80 and V40 regular insulin? Why do they give me either?
53. How did they know I had tuberculosis after my operation and not before?

IV. *Rehabilitation*

1. I am on Class II. What does this mean?
2. After three weeks of first admission patient asked for a class on "How to be a patient."
3. What good is a man with only one functioning lung which is diseased at that?
4. What have you learned in classes that I should do if I want to get better?
5. Why do I have to stay in bed? I took my own bath at the other hospital.
6. What could Social Service do?
7. What could the Chaplain do?
8. What do you know about the home care program?
9. Some of the fellows told me that even when you're better you can't go to the beach or take off your shirt in the sun for more than five minutes. Is that true?
10. What is the use of going on?
11. A patient asked when being interviewed soon after admission whether he could take courses while here in the hospital?
12. Is it possible to bowl and swim and do other sports even if you have tuberculosis?
13. If patient is treated for 1 year and 6 months and is still advised to remain in hospital doesn't this indicate his case is hopeless?
14. Don't you think that forcing a man to stay on a ward such as this with all the restrictions involved will help to make "him soft in the head?"
15. If bed rest should be flat how can someone with asthma prevent coughing and wheezing?
16. Why in some hospitals if on bed rest do you go to x-ray by walking?
17. Does sitting up in bed cause the lungs to breathe faster than lying down in bed?
18. This question was asked by a newly admitted patient being interviewed by student nurse. How soon will I be able to get a pass?
19. Is work such as painting where your hands are above your head dangerous?

V. *Miscellaneous*

1. Does the heart touch the diaphragm during breathing?
2. How thick is the lining surrounding the lungs?
3. What do those cartilages, those litte bones in the trachea do?

Outcomes

The outcomes include the following:

1. An earlier presentation of the planned teaching program for patients. While this is now done in the form of demonstration and discussion, plus reference work, it is felt that role-playing might be even more helpful.
2. A revised emphasis in nursing classes to provide the student with necessary information.
3. Reorganization of the nursing class on chemotherapy in the treatment of the tuberculosis patient as a result of the many questions in this area.
4. Greater ability to prepare the student more realistically for her function as a health teacher in the nursing care of the tuberculosis patient.
5. Use of the 120 questions (a) as a part of the pretest for the students; (b) as a part of the orientation of nursing service personnel to patient care and patient teaching.
6. Realization of the need for much more extensive exploration of the patients' health information needs.

We feel that this same type of survey could be used in other clinical areas, the questions received being evaluated in terms of the individual situation.

Advances and Trends in DRUG THERAPY

by JOAN SARVAJIC, R.N., M.S., M.D.

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Problems in the Management of Hepatic Coma

THE management of hepatic coma is fraught with problems. This is probably because the basic pathogenesis of this syndrome complex is still not clearly understood. In this article a review of the present day management of hepatic coma will be discussed as well as the underlying pathology and clinical features of this syndrome.

The term hepatic coma is used to describe the various stages of impairment of consciousness encountered in patients with liver disease. The changing nature of the hepatic coma state and its reversibility in short term cases without apparent residual disorder of consciousness give support to the concept that hepatic coma is a form of "cerebral intoxication" due to altered function rather than altered structure.

Three stages of hepatic coma have been arbitrarily defined: precoma in which the first stage is that of mild or marked confusion; the second stage is one of stupor but the patient can still be aroused; the third stage is frank coma. This last stage may not occur for weeks or months or may never occur. On the other hand, the first two stages may be very short and frank coma may be the presenting symptom.

Precoma is frequently difficult to recognize since there may be marked variation in signs and symptoms from hour to hour or day to day. Loss of memory for recent events, nonspecific personality changes and intellectual deterioration are common. Speech is slow and becomes slurred as the patient approaches stupor. Perseveration is a frequent finding. Hyperventilation, flapping tremor, increased deep tendon reflexes and Babinski and plantar withdrawal response all become more marked as the patient approaches stupor.

Patients in true hepatic coma breathe slowly and deeply. Fetor hepaticus, a characteristic odor to the breath, is almost always present. It decreases after the intestinal tract is cleared of feces and after the administration of antibiotics which change the intestinal flora. The degree of coma fluctuates as well as the neurological changes.

When the coma is of a lighter degree, the patients may respond to painful stimuli and deep tendon reflexes may be exaggerated. The so-called flapping tremor may occasionally be elicited by supporting the patient's forearm. Again as in precoma, the Hoffman sign is frequently present and the plantar response is commonly extensor but varies. Perhaps the most common neurological change is a plantar withdrawal response, but this and the other signs may disappear as coma deepens. In deep coma, convulsive seizures have been described but these are rare. Severe potassium depletion, with its accompanying muscular weakness and hyporeflexia, may mask all the signs.

For the physician, the diagnosis of hepatic coma must be a diagnosis of exclusion. History and physical findings compatible with liver disease, together with evidence of some precipitating factor are strong points in making the diagnosis. However, the patient may also have other related or unrelated lesions leading to coma. The diagnostic work-up must therefore rule out the differential diagnosis for coma. Lumbar puncture, blood sugar, serum acetone, serum ammonia and urinalysis, may all be used as diagnostic aids.

It is of interest that on rare occasions, patients with little evidence of parenchymal liver damage either clinically or by laboratory determination may develop hepatic coma. It is presumed that in such cases there is a portal-systemic venous shunting which enables the portal drainage to by-pass the liver.

Pathologic Changes in Hepatic Coma

Characteristic and apparently specific changes in the protoplasmic astrocytes of the brain have been described in hepatic coma. Their extent may parallel the duration and severity of coma, appearing within several days of its onset. The lag in appearance of these microscopic changes suggests that they are the result of the coma rather than its cause. In chronic hepatic coma, the microscopic changes may reflect permanent damage and account for the failure of some patients to recover completely even after treatment. It may also explain the failure to correlate chemical findings with clinical ones.

It is current belief that nitrogenous materials, many of which originate in the bowel, play a major role in the production of hepatic coma. These substances, which normally pass through the liver and are detoxified, escape into the general circulation. This occurs either because the diseased liver cannot handle them or because of natural or surgical shunts around the liver. The exact chemical substance or substances responsible for hepatic coma have not been clearly delineated. It has been shown that ammonia and ammonia-containing compounds administered orally can precipitate hepatic coma. It also seems likely that other substances such as bacterial metabolites of methionine may be equally effective.

Common precipitating factors of hepatic coma include blood in the intestinal tract, a high protein diet, ammonium chloride or ammonium exchange resins, mercurial diuresis, paracentesis, diamox, diuril and hydrodiuril, and potassium depletion. It is emphasized however that the use of the aforementioned diuretics in patients with decompensated cirrhosis will not ultimately lead to coma. Quite on the contrary, these medications may constitute appropriate therapy to decrease ascites and can be used cautiously.

Because the pathogenesis of hepatic coma is not completely known and it is not clear whether single or multiple metabolic abnormalities induce its signs and symptoms, the diagnosis of this syndrome remains largely a clinical one. There are no laboratory procedures which give unequivocal proof of hepatic coma. Those which are said to be fairly specific, such as blood

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ammonia levels, correlate poorly with the degree of cerebral intoxication.

The Role of Ammonia in Hepatic Coma

The evidence that ammonia plays a role in hepatic coma has been summarized by Sherlock and McDermott. It is known that ammonium salts administered orally to man can precipitate coma. However, it is also clear that there is a poor correlation between symptoms and the level of ammonia measured in the blood. This latter fact may be a result of poor techniques in ammonia measurement itself. Secondly, there are those who argue that arterial ammonia levels are more likely to be representative of the concentrations reaching the brain.

The exact effect of ammonia on the central nervous system is still in the hypothetic state. One hypothesis suggests that ammonia interferes with the citric acid cycle by removing alpha-ketoglutarate, a key substance in the cycle. This hypothesis is supported by the decrease in alpha-ketoglutarate in the brain tissue following the infusion of ammonia-containing Ringers solution into the carotid arteries of dogs.

Effects of Respiratory Alkalosis on Ammonium Metabolism and Toxicity—Hepatic failure has been associated with low plasma carbon dioxide content and this was in the past assumed to represent metabolic acidosis from accumulated amino and other acids. Vanamee, *et al.*, reproduced respiratory alkalosis in animals by infusion of ammonium acetate. It has been postulated that ammonia which moves as free ammonia from an alkaline to an acid medium would be driven intracellularly where it presumably exerts its effects by an alkalosis.

The increased toxicity of ammonium salts in an alkaline medium has been demonstrated. Krebs showed that hepatic utilization of ammonia for urea synthesis was impaired by lowering the concentration of bicarbonate. In addition to these direct effects of respiratory alkalosis on ammonium metabolism, there are notable similarities between the findings in hepatic coma and those of respiratory alkalosis without liver disease. Respiratory alkalosis causes definite neurological changes including convulsion. The electroencephalographic pattern is similar to that of hepatic coma.

Electrolyte Depletion in Ammonia Intoxication—Among the electrolytes found to be abnormal in hepatic coma, potassium is of considerable importance. Total body potassium is frequently low in chronic liver disease and it has been suggested that this is partly due to low intake and to losses secondary to negative nitrogen balance, vomiting and diarrhea. In pre-coma and coma, hyperventilation causes further loss of potassium. Potassium depletion is accompanied by intracellular acidosis and this favors the intracellular accumulation of ammonia. In some studies, treatment of potassium depletion was of major importance in the recovery of hepatic coma patients.

Other electrolytes are abnormal in hepatic coma, including zinc. Since zinc is an integral part of glutamic dehydrogenase which converts glutamic acid to alpha-ketoglutarate and since it has been postulated that the decrease in cerebral oxygen consumption noted in hepatic coma is related to a decrease in alpha-ketoglutarate, it is possible that zinc deficiency plays an important role in hepatic coma.

The Treatment of Hepatic Coma

Patients may recover spontaneously from coma without any form of therapy. Usually however, they are treated simultaneously with a multitude of therapeutic modalities aimed at various specific and non-specific metabolic abnormalities. If they recover, it is virtually impossible to tell which of the treatments, if any, was responsible.

Nevertheless, the management of hepatic coma at present is directed toward the removal of known precipitating factors and at the correction of known metabolic abnormalities.

Restriction and Removal of Protein—The restriction of protein and the removal of protein (as blood in episodes of gastrointestinal bleeding) from the intestine is of importance in therapy. Daily colon lavages as a means of removing toxins from the large bowel is an important aspect of medical management and the nurse must recognize the reason for its daily order.

The dietary management may require that all protein be curtailed temporarily. Since it is also known that protein is important for the regeneration of liver, restriction should be cut as soon as possible increasing the intake in 20 gram increments every two or three days until a reasonable level is reached. Temporarily the caloric requirements are met with glucose. Oral glucose may cause diarrhea and electrolyte loss. Therefore, glucose may be given intravenously in 10 or 20 per cent solution giving not less than 200 grams every 24 hours.

Vitamins are routinely added because many of these patients may have pre-existing deficiencies and because the high carbohydrate intake may require additional B vitamins. Vitamin K preparations are given when the prothrombin time is elevated.

Parenteral Therapy—Parenteral therapy should not only supply glucose and vitamins but must also be aimed at the correction of hemodynamic and electrolyte abnormalities. In the bleeding patient, transfusion is indicated to restore blood volume. The importance of blood cannot be overemphasized since the already debilitated liver cannot stand further anoxia. In addition, the synthesis of ammonia into urea in anoxia is further impaired causing an increased load of ammonia in the peripheral circulation. Fresh blood however is desirable since stored blood contains ammonia in fairly high concentrations and also because fresh blood contains the labile clotting factors.

When patients reaccumulate fluid rapidly after paracentesis or diuresis and become hypotensive or lapse into coma, plasma is indicated. As much as two liters may be given to restore blood volume. If there is any question of bleeding, fresh frozen plasma which has labile clotting factors is indicated. Failure to replace plasma losses not only leads to hypotension and inadequate perfusion of liver, but also to low salt syndrome.

Electrolyte Replacement—Because of potassium depletion, already mentioned as a common occurrence in hepatic coma, potassium supplements are used. Forty milliequivalents per liter of potassium chloride are added to the glucose and water. The use of potassium chloride is contraindicated if urine output is inadequate. In some experimental therapy, one cubic centimeter of 50 per cent magnesium sulfate in one liter of glucose and water has been given bi-weekly to patients in hepatic coma. Results are difficult to evaluate. Decrease in the fine tremor associated with hepatic coma is sometimes noted.

Antibiotics—Antibiotics are administered to alter the bacterial flora of the bowel to reduce ammonia formation. Neomycin is most widely used although tetracyclines and paromycin have been used. In acute cases, six grams of neomycin are given orally daily in divided doses. In chronic cases 4 grams may be administered indefinitely. Neomycin has the advantage of having little systemic effect, not producing diarrhea and permitting the ingestion of a higher protein diet. Chronic administration can induce a sprue-like syndrome in some patients.

Glutamic Acid—Glutamic acid has been used as an adjunct with varying results. It has been demonstrated that glutamic acid lowers the blood ammonia and that it protects rabbits from convulsions induced by intravenous ammonium chloride. Presumably this is accomplished by the conversion of glutamic acid to glutamine by the uptake of ammonia. Since glutamic acid is always administered as the sodium salt, its administration increases plasma bicarbonate which in return increases total body oxygen consumption peripherally and in brain slices. Since oxygen consumption is depressed in hepatic coma, it is possible that it is the bicarbonate in itself which is beneficial. It is interesting to note that an elevation in bicarbonate increases urea production by the liver and therefore might be expected to lower blood ammonia.

Whether glutamate or alkalosis or both improve the patient with hepatic coma, it is clear that the results are not uniformly good. Decrease in coma in man is rarely seen with dosages under 100 grams of sodium glutamate. This is given in 3 liters of 10 per cent glucose in water over a period of 24 to 36 hours. This will cause metabolic alkalosis and hypokalemia and therefore 40 milliequivalents of potassium chloride is added to each liter of glucose and glutamate. In spite of hypokalemia, a dramatic improvement in the sensorium is occasionally seen.

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GLUTAVENE — METABOLIC AGENT

DESCRIPTION: Glutavene is a solution of monosodium 1-glutamate and monosodium and monopotassium 1-glutamic.

ACTION AND EFFECTS: This preparation of glutamic acid supposedly lowers the blood ammonia presumably by the conversion of glutamic acid to glutamine by the uptake of ammonia.

Glutamic acid has been carefully studied for antiepileptic activity by a variety of laboratory technics and in several species of animals. The amino acid was found ineffective in the prevention or modification of electrically and chemically induced convulsions. It was also shown to be without influence on the normal EEG or the slow-wave dysrhythmia produced by pentylenetetrazol. It therefore differs from all other clinically employed antiepileptics which are effective in one or more of the tests enumerated.

USES: Glutavene has been used for the treatment of coma and other encephalopathies associated with high blood ammonia levels in so-called hepatic coma.

Glutamic acid has been proposed as an agent for the symptomatic treatment of petit mal and psychomotor epilepsy. Mental and physical alertness were believed improved. Grand mal was either not influenced or made worse by glutamic acid. Best results were obtained when the medication was used in conjunction with other specific medication.

Clinical reports have cited several studies of the role of glutamic acid in cerebral metabolism and function intended to explain the mechanism of its action in epilepsy. Similarly the influence of glutamic acid on mental processes was investigated. It was reported to enhance simple maze learning by rats and to improve the intelligence quotient of all subjects with secondary mental deficiency.

PREPARATIONS: Glutavene is supplied in 100 cc. vials containing the equivalent of 25 grams of 1-glutamic acid.

DOSAGE AND ADMINISTRATION: For the average adult, 100 pounds or over, one 100 cc. vial is mixed with 1000 cc. of 5 per cent or 10 per cent glucose in water. This amount should be given intravenously during a four-hour period.

In the use of glutamic acid in epilepsy as little as 4.8 grams per day is reported as effective in petit mal.

TOXICITY: There is no actual toxicity from these preparations however they must be given with extreme caution in the presence of oliguria. The drug is contraindicated in the presence of anuria.

PRECAUTIONS: The alleged value of preparations of sodium glutamate in hepatic coma requires confirmation.

Likewise, numerous clinicians have been unable to confirm the good results reported for glutamic acid in epilepsy. Considering the daily protein intake of adults of approximately 70 grams of protein which provides 7 to 10 grams of natural glutamic acid, the doses reported to be of therapeutic benefit in petit mal seem almost superfluous.

If further clinical work substantiates the reported value of glutamic acid in epilepsy, the mechanism of its action is likely to prove considerably different from that of the known anticonvulsant drugs in clinical use. At present one would be unable to predict from the results of laboratory investigations that glutamic acid has high antiepileptic potency.

There is highly controversial literature on the use of glutamic acid in persons with various types of mental deficiency. Suffice it to say that most of the carefully controlled observations fail to reveal a beneficial effect of the compound on mental performance or learning in experimental animals or man.

SOLU-CORTEF — STEROID

DESCRIPTION: Sterile Powder Solu-Cortef is the sodium succinate ester of hydrocortisone. The notable property of this ester is its high solubility in water. Thus it is particularly suitable to intravenous use, especially in emergency situations where immediate high levels of circulating hydrocortisone are required. The small volume of diluent necessary permits rapid administration.

ACTION AND EFFECTS: The action of this steroid is profound and diverse. Gluconeogenesis, the production of carbohydrate from substances other than sugars, occurs. The drug has a direct effect on the endogenous protein metabolism. Retention of sodium with loss of potassium occurs in people with Addison's disease. The drug is anti-inflammatory. Increased tubular reabsorption of water occurs.

USES: In general the indications for Solu-Cortef are the same as those for Sterile Solution Cortef, the intravenous preparation. These include the treatment of acute adrenal cortical insufficiency; shock unresponsive to standard anti-shock therapy; acute hypersensitivity reactions such as status asthmaticus and allergic drug reactions; disseminated lupus erythematosus; and overwhelming infections with severe toxicity when the nature of the infection has been established and appropriate antibiotic therapy instituted.

Solu-Cortef may also be employed as prophylaxis against precipitation of acute adrenal insufficiency in the event of emergency surgery or other undue stress in patients who have received corticosteroid therapy during the previous year. For elective surgery such individuals can obtain support with longer acting intramuscular corticosteroid perparations.

In hepatic coma, although the mechanism of action is not known, corticosteroids have been utilized in terminal patients in conjunction with other therapy with striking temporary improvement.

PREPARATIONS: This preparation is provided plain in vials; with sterile water in vials each accompanied by one 2 cc. ampule injectable sterile water. Mix-O-Vial Solu-Cortef provides 100 mgm. of hydrocortisone as hydrocortisone succinate and 1.8 cc. of sterile water in separate compartments in the same container. A mixture of the two components will result in a solution which is approximately isotonic with human blood serum.

DOSAGE AND ADMINISTRATION: To prepare solution for injection, add 2 cc. of Sterile Water for Injection or Sterile Isotonic Sodium Chloride to the contents of one vial of Sterile Powder, Solu-Cortef, 100 mgm. The resulting solution is approximately isotonic with human blood serum. The usual dose is 100 mgm. injected intravenously over a period of about one minute. Subsequent doses of 50 mgm. may be given as required.

TOXICITY: Since there is gluconeogenesis, one most be sure that glycosuria does not result with a diabetes mellitus that is artificially produced. Secondly, the blood pressure must be checked in order that signs of hypertension may be quickly noted. The presence of a moon face may not always be avoided since the patient may require the medication. Retention of water can also be checked by weighing the patient daily.

PRECAUTIONS: When the drug is to be discontinued it must be done slowly to prevent adrenal crisis. It must actually be a weaning process with the dose of the drug being slowly decreased each day.

POTASSIUM — CATION

DESCRIPTION: Potassium is the chief cation of the body cells. The functional integrity of the cell is dependent upon an adequate potassium intake.

ACTION AND EFFECTS: The potassium ion although necessary for cell function and as a building stone in cell structure, is a highly toxic substance when present in extracellular fluid in a concentration of only a few milliequivalents per liter in excess of normal. Under these circumstances, the drug has a marked effect on muscular and nervous activity and can cause death from cardiac depression. Conversely a negative potassium balance with an associated hypokalemia is not long compatible with life.

USES: One of the most outstanding advances in electrolyte therapy during the past decade has been the appreciation of the frequency of the occurrence of potassium imbalance. Potassium deficiency seldom occurs as an entity but is usually accompanied by other disturbances in electrolyte metabolism.

Thus potassium is used to replace a deficiency in such situations as a hepatic coma, infantile diarrhea, acute gastroenteritis in the adult accompanied by marked diarrhea, following surgery when it is common to have potassium loss postoperatively which requires replacement, and in diabetic acidosis.

Potassium salts are also used as osmotic diuretics, and as a specific in Familial Periodic Paralysis, a rare myopathy associated with a loss of potassium.

The drug is also used (with no good rationale other than empirical evidence) in the treatment of Ménière's Disease and in a number of allergic diseases.

PREPARATIONS: When the actions of the cation are desirable the preparations of choice are potassium chloride, potassium acetate, potassium citrate, and potassium nitrate.

ADMINISTRATION AND DOSAGE: The dose of potassium is an enigma. There is no formula which can be applied to determine the extent of a negative potassium balance. Fortunately therapy need not be directed toward complete replacement. A partial correction of a potassium deficit usually leads to a very salutory response. In adults, the daily administration of 50 milliequivalents per day, approximately 4 grams of potassium chloride, will cover all but the most unusual losses and initiate repair.

There is no virtue in the parenteral administration of potassium. If feasible, potassium should be given orally as tablets.

If it must be given parenterally the rate of intravenous infusion in a liter containing 40 milliequivalents should not exceed 15 milliliters per minute.

TOXICITY: Potassium intoxication can occur whenever the rate of intestinal absorption, parenteral administration, or endogenous accumulation of the ion in the extracellular fluid exceeds the rate of renal excretion. The most common causes of potassium intoxication are an extreme degree of renal insufficiency or too rapid intravenous administration of potassium salts.

It is difficult to produce potassium intoxication by oral administration of potassium salts when renal function is adequate. The exceedingly large doses that would be required would not be tolerated by the gastorintestinal tract, and pylorospasm and vomiting preclude the possibility of adequate absorption.

PRECAUTIONS: A real danger attends the intravenous infusion of solutions containing potassium in concentration greatly in excess of the normal extracellular level of the ion.

Potassium can be removed by the use of the artificial kidney, but this requires elaborate equipment and highly trained personnel. In the event of acute renal shutdown of a reversible nature, potassium intoxication should be anticipated and delaying procedures instituted such as the use of cation exchange resins.

NEOMYCIN — ANTIBIOTIC

DESCRIPTION: Neomycin is an antibiotic derived from the metabolism of Streptomyces fradiae, a microorganism isolated from the soil. Chemically neomycin may be a complex of closely related substances. The chemical structure is unknown.

ACTION AND EFFECTS: Neomycin exhibits a broader spectrum of antibacterial activity than does penicillin, bacitracin or streptomycin and is effective against a variety of organisms, gram-positive, gram-negative, against acid-fast bacilli and actinomycetes. It is more active against staphylocci than streptococci. Some strains of Proteus and Pseudomonas are susceptible to the drug. The efficacy against organisms of the genus Clostridium is variable. The drug markedly and rapidly inhibits the coliform bacteria in the intestinal tract, but there is no appreciable effect on the stool content of anaerobic bacteria. Fungi and viruses are resistant to the antibiotic. Pus, exudates, gastrointestinal secretions, bacterial growth products and enzymes do not inactivate neomycin.

Uses: Topical Application: Neomycin has been successfully employed in a wide variety of medical and surgical infections of the skin and the mucous membrane, caused by bacteria susceptible to the antibiotic. Included in the conditions treated are burns, wounds, ulcers, impetigo, infected dermatoses, furunculosis, otitis externa, conjunctivitis, and sty.

Intestinal Antisepsis: Neomycin has been employed prior to large bowel surgery, in a manner similar to that for streptomycin and certain of the sulfonamides with similarly beneficial results. The coliform count of the intestinal contents is quickly reduced almost to zero. However, since yeasts, and in some cases, A. aerogenes soon replace the normal flora, neomycin therapy should not be continued for longer than 72 hours prior to surgery.

Other Uses: Neomycin is occasionally given intramuscularly in the treatment of severe systemic infections, despite the possibility of serious neurotoxic and nephrotoxic reactions. Infections caused by S. aureus, K. Pneumoniae, H. Influenzae, E. Coli, and Pseudomonas and Proteus organisms have responded well to neomycin.

PREPARATIONS: Neomycin Sulfate, U. S. P., is available for topical and oral administration. It is marketed as a powder in 0.5 gram tablets and in dermatological and ophthalmic ointments containing 5 mgm. per gram of a suitable base.

DOSAGE AND ADMINISTRATION: For topical use the ointment can be applied to the skin or mucous membrane two or three times daily. The drug may be used in isotonic sodium chloride solution as a wet dressing, irrigation, or instillation.

For intestinal antisepsis prior to large bowel surgery or in hepatic coma, 1 gram of neomycin is given orally every hour for four doses and then every four hours for one dose for not over three days prior to operation. The patient going for surgery is placed on a low residue diet and given a saline cathartic. In cases of emergency bowel surgery, as 1 per cent solution of neomycin sulfate in isotonic sodium chloride solution may be instilled in the intestinal lumen. Volumes up to one liter have been employed. Spillage of this 1 per cent solution into the peritoneal cavity should not exceeed 50 milliliters.

TOXICITY: Because of its poor gastrointestinal absorption, oral neomycin rarely causes systemic toxic effects. It often causes frequent loose stools and sometimes induces nausea. Prolonged oral therapy can result in overgrowth of nonsusceptible microorganisms in the intestinal flora.

PRECAUTIONS: Oral therapy with neomycin should not be continued for more than three days and is contraindicated for cases of intestinal obstruction. Applied topically the drug is well tolerated, relatively nonirritating, and has a low index of allergenicity.

Injected parenterally neomycin may cause serious but usually reversible renal injury. Neomycin has also caused damage to the eighth cranial nerve which is irreversible. The disturbance is mainly auditory.

Mary Barrett, assistant chief, Nursing Education, tells associate editor Julie E. Miale, R.N., about team nursing, what it is and how it works in practice.

TEAM NURSING—

A Definition and Appraisal

Q. Miss Barrett, since we are going to talk about TEAM NURSING, would you like to say briefly what you think team nursing means?

A. We think of team nursing as an administrative framework in which we do nursing. We feel that by operating within this framework, we make the best possible use of the personnel we have. Professional nurses are appointed as team leaders according to their knowledge of the patient, the judgments they are capable of making, and their ability to get along with others.

Q. You mean that by placing the professional nurse in this position of leadership, you are able to make better use of auxiliary personnel?

A. Yes, team nursing seems to be working for us. Even though we do not have an adequate staff of graduate nurses, this method provides comprehensive care for the patient. In this way leadership is provided by the professional nurse, and each nonprofessional member of the team makes a practical contribution to the patient's care. The team leader's job is "patient-centered" and not "job-centered," as it is in the functional method of nursing.

Q. The professional nurse, then, tries to correlate the needs of the patient with the skills of the auxiliary worker, doesn't she?

A. Yes; and then, too, we hope the auxiliary worker will improve and eventually demonstrate a high degree of proficiency in patient care.

Q. What constitutes a "team" in team nursing?

A. Ideally the team consists of a professional nurse who is the team leader, a professional nurse who is a staff nurse, a practical nurse, and ancillary workers—or nursing assistants, as we call them here.

Q. Is team nursing practical in all areas of the hospital and on all shifts?

A. Yes, we stick to the team nursing framework as closely as we can in all areas of the hospital. Of course, it works better in some areas than in others. Actually, we utilize all the devices of team nursing: the nursing care plans, the conferences, and the team techniques of teaching. We advocate teaching on the job to improve skills of team members, and, in turn, to improve patient care.

Q. What are the main functions of a team leader?

A. First of all the team leader must understand the patient's condition and medical care plan, she must be able to break down this medical care plan to a nursing care plan. Then, with this knowledge and her knowledge of team members, she attempts to match the needs of each patient with the capabilities and personality of the worker. She guides the team members as they assume their responsibilities. She supervises the work of every team member. She teaches. She counsels. She is a resource person. She cares personally for the seriously sick patient whenever necessary. She is responsible for meeting the patient's nursing needs, as if she alone were in charge of each person in her group.

Q. Are there times when the team leader is also the head nurse and responsible for all the patients on the floor?

A. Oh, yes, this happens. She may have to relieve a head nurse and be a team leader, too. Or, it may be the other way around and the head nurse may have to be a team leader. Many times we are hard pressed so that one nurse performs a dual role.

Q. Suppose there is only one professional nurse and one assistant covering a floor—do you still consider this "team" nursing?

A. Yes, we do. Even where there is one professional nurse with one practical nurse or one assistant, the concept of team nursing is utilized. In addition to patient care, the team activities, the teaching, and the problem solving go right on, with the professional nurse acting as the leader.

Q. Would you say this is a new way of nursing and is it so very different from what was done in the group, functional, or case method?

A. I would not say team nursing is new; it is rather an evolution, a growth. Actually, it is a combination of all three earlier methods—the case method, functional, and group nursing.

Q. In other words team nursing is organized to utilize to best advantage the variety of people who are involved in nursing service today.

A. Yes, we have found this to be so.

Q. Doesn't this also involve delegating some of the responsibilities of the head nurse to the team leader?

A. It would be wonderful if this were always possible. We do work toward a decentralization, but unfortunately the head nurse many times has two jobs. Today there is a wide variety of people involved in nursing service, and the head nurse must work with all of them. The team method seems to be the best way to fit all the nursing personnel into nursing service. It works for us here and we like it.

Q. A combining of forces to give good patient care sounds good to me. I gather, too, from what you say that a good communications system is set up via this team. As a result there is a combined effort to observe and interpret each patient's needs and to meet those needs. Am I right?

A. Exactly; you see, the team leader meets her group at the daily conference. She directs the assigning of patient care, with the team participating, making plans, and offering suggestions. She accepts their suggestions and then acts accordingly and in line with the assessments she makes. She does not set down any hard and fast rules. The assignments are not cut and dried. They are subject to change whenever necessary.

Q. In other words, if Mrs. A, a patient, demonstrates a hostile attitude toward Miss B, the aide, and is upset and uncooperative, has Miss B an opportunity to talk this over with the team leader at the conference and get it straightened out?

A. Such a problem would be talked out at the conference, unless the situation called for immediate action. A good team leader would explore the patient's attitude. She would try to find out why the patient acts this way. Patient care is not assigned in the old arbitrary way, where the worker was assigned to a particular part of the ward and had to care for the patients on that side of the ward or floor regardless of diagnosis, patient needs, or her skills and abilities.

Q. Does the team leader see every patient in her group every day?

A. A team leader may have a critically ill patient who takes up a great deal of her time. This patient may require her specialized skills for the greater part of the day. Yet, because in team nursing she is able to divide her work with the ancillary personnel, she does get an opportunity to supervise the care of a larger group of patients and usually does get to see every patient every day. We think this type of care is *safer* for the larger group of patients.

Q. Does the team leader have a period of orientation, or is the professional nurse expected to step right into a team job?

A. We try not to make a new nurse a team leader. She usually works as a staff nurse on a team for about a month. During this period she is given an orientation which includes four hours of leadership and four hours of team nursing workshop, where she learns the structure of the team and how to manage a group. During this time we evaluate her abilities as a leader. Not all professional nurses qualify for this position of leadership.

Q. Let's consider a statement made by some nurses who say, "Team nursing cannot work in all hospitals"; what do you think about this?

A. All I can say is that it works for us. We feel that it is the best way to utilize the various services the nonprofessional has to offer. It is in the best interests of the patient. Although some nurses do complain about it at first, they find it works well when there is a desire on the part of each member of the team to join with others in coordinating patient care.

Q. When are team conferences held and what goes on usually at these conferences?

A. Usually we try to arrange them at a definite time, with a planning conference scheduled in the morning and an evaluating conference in the afternoon. The time is not terribly important, however. We let each team choose its own time. Sometimes the conference is held after lunch when the patients are having their quiet hour, sometimes at two-thirty, and sometimes at four.

The planning conference held in the morning is usually short, because much of the planning has taken place the day before, except in the case of new patients or if changes have occurred during the night. The evaluation conference usually takes longer, for it is an appraisal of the day's work and has a specific agendum: evaluation of the day's work with the patients, teaching, and planning for tomorrow.

The team leader leads the discussion. Problems are thrashed out. For instance, sometimes patient care is moving backward—instead of gaining strength, tone, etc., the muscle gets weaker. What's to be done? How and by whom and so on? Out of these discussions comes a plan for the next day, so that a team leader has an outline to start with. This is especially helpful when there is a change of team leaders because of a day off. This shortens the morning conference. The evaluation done the day before helps the next day.

Q. What about teaching?

A. There is a definite period of teaching. The conference period affords an excellent media and is part of the team's work, even though teaching is done throughout the day as well.

Q. Then, having an understanding of the patient and his condition makes for better nursing care, wouldn't you say?

A. Absolutely. An aide for instance, who knows something about her patient's condition, what to look for, and what to expect is certainly a better aide. If she knows why her patient is irritable, apprehensive, fearful, running a high temperature, she is better able to meet his needs. We find that our aides are better people and better aides because we teach them the things they are interested in knowing in order to give adequate care. They recognize that we value them, and they value us in turn.

Q. Let me ask one final question: The professional nurse is responsible for nursing service, for patient care, in its entirety. She is an independent practitioner, is she not?

A. Yes, she is an independent practitioner in every area except one and that is in relation to carrying out the doctor's orders. To that extent her role is dependent, but the area of nursing care is hers and hers alone.

Interaction of Nursing Personnel with Schizophrenic Patients

This study investigates whether hospital nursing personnel interact more frequently with chronic schizophrenic or with acutely ill psychotic patients on the same unit.

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THERE are numerous references in the nursing literature stating that the preconceived ideas of nursing personnel about the patient influence the kind of care the patient receives. Tudor[1] found that labeling a patient "hopeless," "unresponsive," or "assaultive" served as a convenient rationalization for the staff to avoid the patients. However, in most mental hospitals the chronic patients are cared for in units which are separate from those that house the acutely ill psychotic patient, and there is little chance to ascertain whether nursing personnel, given a situation where they had equal opportunity to interact with both chronic or acute patients, would show a preference.

The Problem

Thus to determine, through quantitative measures, whether nursing personnel interact more frequently with chronic schizophrenic or with the acute psychotic patients on the same unit the following specific questions* must be answered:

1. With whom do nursing staff interact on the wards?
2. Do professional nurses interact more frequently with acutely ill than with chronically ill patients?
3. Do attendant nurses interact more frequently with the acutely ill than with the chronically ill patients?
4. Do nursing staff interact more or less frequently with patients of the same sex as the staff member?

Definition of Terms

For the purpose of this paper "acute patients" were defined as those who had psychotic symptoms for two years or less and who at the onset of this study had been hospitalized for less than a year. "Chronic patients" were defined as patients who had definite schizophrenic symptoms for four years or longer and who had been hospitalized for schizophrenia for at least two years. "Interaction" was defined as being actively engaged in activity with a group or in activity with another person such as a patient or staff member. "Noninteraction" was defined as any

TABLE I

MEAN NUMBER OF INTERACTIONS OF STAFF ACCORDING TO SEX AND DIAGNOSIS OF PATIENTS

	Mean No. of Interactions			Mean No. of Interactions		
	Chronic Female Patients	Chronic Male Patients	Signif.	Acute Male Patients	Acute Female Patients	Signif.
Graduate Nurses	14.3	6.1	N.S.	11.4	6.6	N.S.
Female Attendants	18.0	6.0	0.1%	33.2	13.7	0.1%
Male Attendants	7.4	19.2	1 %	12.6	25	1 %

* The author wishes to express appreciation to the Nurses' Seminar who assisted in setting up the research design and collecting the data.

[1] Gwen E. Tudor, "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward," *Psychiatry*, Vol. 15, No. 2 (May, 1952), pp. 193-217.

FIGURE 1

CHECK SHEET FOR SPOT CHECK OBSERVATION

Ward 4 South Time 8:15 AM Date 7/16/58 Observer HMK

Patient	Type of Interaction				Object of Interaction						Off-Ward		Comments
	Int.	Act: N.S.	N.I.	?	P	S	G	A	D	Other	Soc.	N.S.	
1. Allard		✓											
2. Cook	✓				4		2						
3. Emmons												✓	Doctor's appt.
4. Farmer					2		2						
5. Glory													
6. Hall													
Personnel													
1. Lee, A.N.			✓										Charting
2. Carl, R.N.	✓												
3. Doe, A.N.					2, 4								

Type of Interaction

Soc.—socializing
Act.—active & nonsocial
N.I.—noninteraction

Object of Interaction

P—patient
S—student
G—graduate
A—attendant

Other

VO—volunteer
VI—visitor
OT—occupational therapist
OP—other personnel

Off-Ward

Soc.—socializing
N.S.—nonsocializing

To Read This Figure

1. Patient Mr. Allard was active but nonsocializing.
2. Mr. Cook, patient, was interacting with Miss Carl, R.N., and patient Mr. Farmer—Mr. Farmer was interacting with Mr. Cook.
3. Mr. Emmons was off the unit to a doctor's appointment at the time of observation.
4. Attendant Lee was in the office charting.

activity which did not include a face-to-face contact with another person, such as preparing medications, desk work, telephoning, housekeeping chores, errands off the unit, and personal time.

Delimitations

One limitation of this study was the fact that in some instances nursing personnel were assigned to specific patients. However, since the study is based on observations carried on over an eight-week period and since these assignments were changed frequently this factor was not considered in analyzing the data.

Procedure

A time sampling method [2, 3] called the "spot check" was used to identify the interaction of each of the personnel with patients. A form was developed on which the interactions were recorded (see Figure 1). This paper is based on data derived from 560 spot check observations made ten times a day at random times, seven days a week between the hours of 8 AM and 10 PM for an eight-week period. Trained observers who made the spot checks had an interrater reliability of 96 per cent.

Comparisons were made of the rate of interaction of the professional nurses and the attendants as they related to chronic and acutely ill patients.

[2]Harriet M. Kandler, *et al.*, "A Study of Nurse-Patient Interaction in a Mental Hospital," *American Journal of Nursing*, Vol. 52, No. 9 (Sept., 1952), pp. 110-113.
[3]Robert Hyde, "Socialization Activity Index for a Mental Hospital," *Nursing World*, Vol. 125, No. 8 (Aug., 1951), pp. 343-345.

The data were further analyzed to determine whether there were differences between the interaction rate of the male and female attendants.

The study involved the patients and personnel of one unit which cared for both chronic and acutely ill patients. In addition, male and female patients were housed on the unit, and both male and female staff were assigned here. Thus it was possible to investigate the differences in rates of interaction with respect to chronicity and sex of patients and staff.

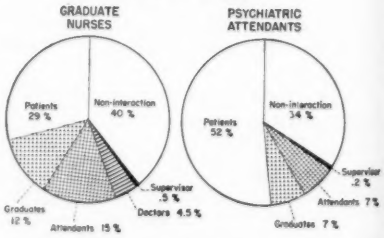
Personnel included in this study were six professional nurses, six female attendant nurses, and six male attendant nurses. Two of the six professional nurses were employed as head nurses (one on each shift); the remaining four were staff nurses. In analyzing the data no effort was made to differentiate the activities of the head nurses from the staff nurses. During the eight-week period of observation there was a daily average of nine chronic schizophrenic patients and eleven acutely disturbed patients on the unit.

Analysis of Data

The total number of observations for each staff member and patient differed; therefore these were prorated to the same total number for all persons before analyzing the data. Thus the figures reported here may be compared directly.

When the data were examined to compare the number of times staff were observed in interaction with the number of times they were observed in noninteraction, no significant differences were found between the professional nurses and the attendants. The professional nurses were observed in interaction during 60 per cent of the spot checks. Although there were no significant differences between the total percentage of interaction of the professional nurses and the attendants, marked differences were found in the kinds of activity which made up the interaction and noninteraction of both

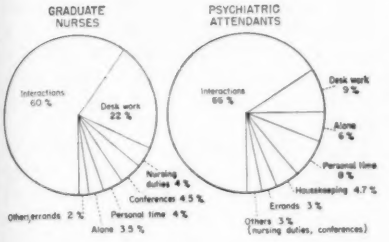
FIGURE II
Distribution of Total Activities with Patients and Personnel in percent



groups. This may be seen in Figure 2. Figure 2 shows the relationship between the noninteractions and the interactions.

FIGURE III

Distribution of Total Activities in Percent



Professional nurses were observed in interaction with patients in 29 per cent of the spot checks while the attendants were observed interacting with patients in 52 per cent of the spot checks. The observations indicated that the attendants were interacting with patients at a significantly higher rate than were the professional nurses and tended to support the fact that the less well-prepared nonprofessional worker interacts more with patients than does the more highly skilled professional nurse.

Twelve per cent of the professional nurses' interactions were with other professional nurses, and in fifteen per cent of the spot checks they were observed interacting with attendants. On the other hand only seven per cent of the attendants' interactions were with other attendants.

A very small proportion of the observations showed interactions of the nursing staff with the doctors. Only four and one-half per cent of the spot check showed the professional nurses interacting with the medical staff, and the attendants were observed in only 0.2 per cent interactions with the doctors.

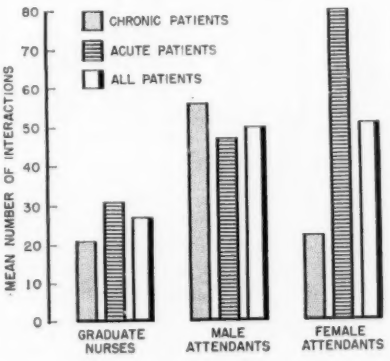
Only one-half of one per cent of the observations showed the nurses interacting with the supervisors, and none of the attendant observations included interaction with the supervisor. The small percentage of interaction with the supervisors is due to the fact that all the observations upon which the study was based were made by the supervisors who acted as nonparticipant observers and therefore discouraged interaction of the staff with them during this period of observation.

When the data were examined to determine how the professional nurses and the attendants were utilizing their time when they were not interacting with patients or staff, some significant differences were found. Figure 3 shows the percentage of observations in noninteracting activities of both the professional nurses and attendants.

These data indicate that during 22 per cent of the spot checks the professional nurses were observed in activities that involved desk work, charting, or telephoning. The attendants were involved in these activities in nine per cent of the observations. In one per cent of the observations the professional nurses were engaged in running errands, and in an additional one per cent of the spot checks they were doing housekeeping chores. The attendant group was engaged in errands to a greater degree than were the professional nurses (3.5 per cent) as well as in more housekeeping duties (5 per cent). It appears that 24 per cent of the professional nurses' observed interactions were involved in duties that might well be delegated to a clerk, and the attendants were involved in such activities during 17.5 per cent of the observations.

FIGURE IV

Mean Number of Interactions Between Personnel and Patients



The attendant group spent twice as much time in solitary activity (sitting alone, reading the newspaper alone, or watching television by themselves) than did the professional nurse staff (attendants 7 per cent; professional nurses, 3.5 per cent). In addition the attendant group was observed twice as often in activities classified as personal time—such as at coffee breaks and off-ward rest periods—as the professional nurses.

In four per cent of the observations the nurse was preparing medication or getting ready to carry out treatments; the attendant group was so occupied during 0.6 per cent of the observations.

The graduate nurses were at conferences, review rounds, admission conferences, etc., during 4.5 per cent of the observations while the attendants were observed in these activities during 1.6 per cent of the observations. Figure 3 shows the percentage of noninteracting activities. On the basis of 100 per cent this shows how the noninteracting activities were distributed.

The data were examined to determine whether the professional nurses and attendants interacted more frequently with the chronic schizophrenic or with the acutely disturbed patients on the unit. These data indicate that the mean number of interactions of the professional nurses and the female attendants was higher with the acute than with the chronic patients (significant at <0.1 per cent level). Male attendants on the other hand interacted more frequently with the chronic patients than with the acute (significant at <1 per cent level). These differences may be seen in Figure 4.

Although there was no significant difference between day and afternoon shifts in the mean number of interactions of the staff with all patients considered together, there was more interaction with the chronic patients on days than on afternoons and more interaction with the acute patients on the afternoon shift than on the day shift (Figure 5).

In order to ascertain to what extent the sex of the patient and the sex of the staff member were related to the interaction rate, comparisons were made of the mean number of interactions of the professional nurses, the female attendants, and the male attendants. Table I shows these comparisons. It was found that both the professional nurses and the female attendants interacted more with the chronic female patients than did the male attendants. However, the female attendants and the male attendants interacted more frequently with the acutely disturbed female patients than did the professional nurses. The female attendants interacted more frequently with the acutely ill male patient than did the male attendant.

The male attendants interacted at a significantly higher level (significant at <1 per cent level) with the chronic patients than did either the professional nurses or female attendants.

No significant differences were found between the interaction rate of the professional nurses with either the male or female chronic patients or with the male or female acute patients. However, the differences in interaction rate of the male and female attendants were highly significant. This may be seen in Table I.

From these data it appears that the chronicity of the patient as well as the sex of the patient and staff member affect the interaction rate.

Both the professional nurses and the female attendants interacted more frequently with the acutely disturbed patients than they did with the chronically ill patients on the unit. The male attendants, on the other hand, had a

higher interaction rate with the chronic patients than they had with the acute patients. It is possible that the male attendants are more challenged to work with the chronic patients than are the female staff members. However, during the time that the data were collected for the study there were more chronic male patients on the unit than there were female chronic patients, and there has been a tendency for staff to work with patients of the same sex when they are dealing with acting out behavior, for it was felt that it was less traumatic for the patient to be cared for by a staff member of the same sex as himself. This does not, however, explain the fact that the interaction rate of the female attendants was higher with the acutely disturbed male patients than was the interaction rate of the male attendants. If the female attendants could work effectively with the acutely ill male patients, the data suggest the possibility of further extending the use of female staff working with male patients and of male staff working with female patients.

The data indicate that during the day tour of duty there was a higher interaction rate of staff with the chronic patients than on the afternoon tour of duty, when the interaction rate with the acute patients was higher than with the chronic patients. During the day tour of duty the major part of the physical care—such as somatic therapies, consultations, and testing procedures—was carried out. During the evening tour of duty when more opportunities for social activities of nursing staff with patients are possible, it appears that the staff interact at a higher rate with the acute patients than with the chronic patients.

Need for Further Study

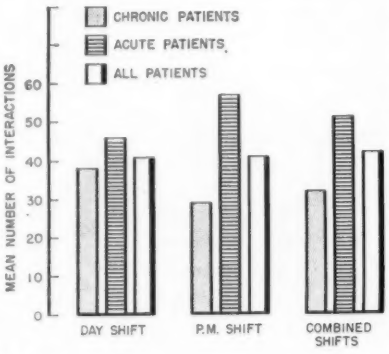
This study of personnel-patient interaction indicated that the attendants were observed in interactions with patients almost twice as often as were the professional nurses. Since it appears that the attendant is the individual who interacts most frequently with patients, added emphasis should be placed on interpersonal skills in the educational program of the attendants. This needs to be done in order to give these workers some of the skills that are needed in working closely with patients. If on the other hand nursing administration feels that the professional nurse, because of her added professional experience and education, is the person who is best equipped to interact with patients, an effort should be made to free this nurse of the routine clerical and desk work so that she has the time and opportunity to interact with patients.

The data indicated that 15 per cent of the professional nurses' interactions were with attendant nurses. This raises the question whether the professional nurses are providing sufficient time for direction of the nonprofessional staff on the unit.

The very small number of interactions of the medical staff with the professional nurses on the unit raises also the question of whether the doctors are giving a sufficient amount of time to directing the care of the patients on the unit, or whether the majority of planning and direction concerning patient care is provided in meetings that

FIGURE V

Mean Number of Interactions Between Personnel and Patients by Shifts



are held off the ward, such as in review rounds and conferences. In only six instances out of 560 observations were the doctors observed in interactions with the attendants, indicating that there is little direct communication between the doctor and the attendant. From the data it appears that the attendant has very little interaction with either his peer group, the doctors, or the professional nurse (total 19 per cent). One wonders whether the attendant sees his position as a rather isolated one. The findings strongly suggest that the attendants might benefit from more support from the physician and thereby might gain a sense of greater participation and investment in the patient's treatment.

When the data were examined to determine what nursing staff were doing when they were not engaged in interactions, it appeared that in 22 per cent of the observations the professional nurses were engaged in clerical duties. It might be well to examine these clerical chores to ascertain whether it would be feasible to employ a ward clerk in this situation. It would be interesting to observe whether the professional nurse, if she was relieved of the clerical work, would spend her time with patients and staff.

Not only were the nurses spending 22 per cent of the observations in desk work and 2 per cent in other clerical duties, but in 17 per cent of the observations the attendants were observed involved in duties which might well be reallocated to a ward clerk. Presumably the kinds of skills needed to deal with patients are different to some degree than those needed to do desk work effectively; it might well be that a person who is interested in being a ward clerk could do the clerical work on the ward more effectively and efficiently.

One might question the reason why the attendants were observed using "personal time" and were observed "alone" twice as often as were the professional nurses. This would lead one to question whether the pressures on the attendants were so much greater than those of the nurses that the attendant had to withdraw from the situation. Another possible explanation may be that the attendants are less able than the nurses to handle the frustrations inherent in the job and need more support in handling their feelings and planning their time.

Summary and Conclusions

Data based on 560 observations made ten times a day at random times over an eight-hour period on a unit which cared for both chronic schizophrenic and acutely disturbed psychotic patients indicated the following:

1. The total interaction rate of the professional nurses was 60 per cent while the interaction rate of the attendants was 66 per cent.
2. Both male and female attendants interacted more frequently with patients than did professional nurses.
3. Professional nurses and female attendants interacted more frequently with the acutely ill patients than with the chronic patients, while there was a tendency for the male attendants to interact more with chronic patients than with acutely disturbed patients.
4. The interaction rate of staff with chronic patients was higher on the day shift than on the afternoon tour of duty.
5. In many of the professional nurse and attendant observations, staff were engaged in activities such as running errands, answering the telephone, and finding charts that might be reallocated to a ward clerk.

By investigating the interaction rate of nursing staff with both chronic and acute patients on the same unit, it was evident that the chronicity of the patient as well as the sex of the patient and staff member influenced the interaction rate.

THE DYNAMICS OF HUMAN RELATIONSHIPS

Let's talk it over

by **THERESA G. MULLER, R.N., M.A.**
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OUR METHODS of adjustment depend on the development of our unique potentials. During the first year of life, a child begins to develop an awareness of his physical identity as apart from everyone else's; everything in his world has a personal reference. This is accepted as a part of childhood, but such an egocentric tendency is not tolerated in later life; the pressures of authoritative direction set limits in the ways of satisfying selfish desires.

Some imposed patterns are incorporated by each developing personality. The effort to maintain biological needs for survival and satisfactions generates the energy of the motivating "id" forces. The developing awareness of self, the "I," has been identified as the "ego." Authoritative or parental direction becomes incorporated as a "superego," or conscience. Growth progression involves the gradual assumption of individual responsibility.

At first, the striving for independence tends toward overruling parental authority but the incorporation of positive values and relationships eventually brings about our ability to be self-directing. A primary integration, then, is an awareness of self and differentiation from the environment. A secondary integration involves unification of internal resources to facilitate adjustment and adaptation to the external environment.

Not only is our development fostered or hindered by the realities of our immediate and cultural environment; it is also influenced by the purposes and goals which arise from within and outside ourselves. We are not passively acted upon by outside stimuli, such as oxygen, food, and water; we select those elements which contribute to our survival, and avoid those which detract from it. We can modify external influences by controlling temperature extremes and acquiring food and other necessities. Survival, however, is not our only motivating force; existence without satisfactions can be unbearable. Each personality develops from relationships in a family, from cultural influences of place and time, from early patterns of adjusting to deprivations and from inability to meet ideals and expectations.

Unifying Factors in Personality

Several unifying factors contribute to personality integration. Self-awareness gives us a sense of personal value and self-esteem. Memory is a bridge between the past and the present. Imagination projects us into future goals toward which we then strive by mobilizing the appropriate resources. Faith in ourselves extends to others. This sense of trust evolves from the way our basic needs were met during infancy. A baby smiles, coos, and acts content in response to the warmth, affection, and the protective handling of another person; conversely, he shows signs of discomfort and mistrust at the sound of a sharp tone of voice or when held insecurely. Further modifications occur with increasing self-awareness and awareness of others. The family constellation can affect the growth potentials of a person by his position as oldest, youngest, or only child, and the attitudes of each member to him.

Cultural Influences of Place and Time

Every culture has characteristic ideals of courage, duty, honor, and self-discipline; a problem arises for each individual in accepting or rejecting the prevailing sanctions. Each of us adopts the ideas and attitudes of our own culture as "right" and those of another as "wrong." From the standpoint of a nurse's values the patient's may be wrong when as a matter of fact his actions are in keeping with his own culture and time.

Progressive Development

A central problem must be taken care of in each stage of life, but desires and conflicts are never entirely resolved in any one stage. Progress to the next stage is relatively

assured when the conflicts of the previous one have been resolved in the best way possible: by compromise with what already exists or by integration or sublimation. Thus, a baby needs to satisfy its sucking and dependency needs with no concern for the social acceptability of the means selected or the person involved. A child needs to learn how to make increasingly acceptable choices in meeting the inevitable frustrations in the satisfaction of his biological or social needs. An adult needs to be able to defer immediate egotistical or biological satisfactions by sublimating them into mature values. Qualities of dignity and stability thereby mark the unique, or individual, personality.

Our spontaneous behavior reflects who we are as a whole; we act automatically on the basis of habits and conditionings. We often deal partially with unimportant or familiar situations, thereby conserving our energy for more important or new experiences. Personality integration is greatest when our sights are directed toward a satisfying achievement or in avoiding harm to ourselves. An overwhelming threat may also be disintegrating. Everyone has experienced the feeling of being powerless and unable to move in the face of an insurmountable danger. On the other hand, we can do several things simultaneously when our lives are relatively free from threat. Integrated activity, then, implies the ability of a person to make appropriate responses to a current situation in accordance with his present stage of development.

In the process of normal development, we come to grips with the realities, which are less satisfying than the fancies built upon our wishes and desires. As we incorporate social restrictions, we may adhere too rigidly to rules and regulations (Freud's pseudoconscience) or become increasingly able to make flexible applications to varying circumstances (the true conscience based on the integration of appropriate values). We learn to evaluate life situations for what they are and to accept our own inevitable limitations. Greater certainty of our responsibilities also makes us able to defend our rights in whatever way seems necessary. This keeps us from being indiscriminately demanding or acquiescent to the wishes of another person; we will not expect others to accede to our wishes without sifting their values and relative rights.

Adjusting to Deprivations

We vary in our individual abilities to cope with deprivations, that is, environmental limitations in meeting our needs for survival and satisfactions. The resulting frustrations are normally handled in a socially and personally acceptable manner depending upon developmental influences which have strengthened or weakened our potentials for meeting the obstructions.

Frustration Tolerance

Each person can tolerate frustration up to a point. Additional stresses then give rise to symptoms similar to those of a neurosis or psychosis, but these speedily disappear when the conditions are modified favorably. Any one of us may automatically follow established standards and goals and appear to be making a satisfactory life adjustment, only to find that a veneer is somewhat easily rubbed off under certain kinds of pressure; thus the relatively undeveloped parts of the self require new or renewed efforts toward further growth. An upheaval is not necessarily unhealthy; it may be the sign of growth instead of faulty adaptation. Therefore, we should guard against settling into a frictionless groove where everything is maintained with surface calm because no disturbing element is willingly faced. For this reason an unduly protective environment may limit a person's development as well as an unnecessarily difficult environment.

Family Relationships

Each child gains a feeling of security from an environment where harmonious parental relationships extend to other family and social relationships. By adequately meeting a child's dependency needs, a sound foundation is laid for growth to mature independence. Conversely, an emotionally deprived child seeks compensatory satisfactions in material and personal achievements or by converting his hopeless feelings into an illness.

Modern trends in child care favor the return to methods discarded as somewhat rigid a generation or so ago. The forward movement, however, utilizes the benefits of flexibility without sacrificing the child's need for order and experience in social conformity. We saw how the infant's first pleasure is feeding, his first dissatisfaction is to being hungry, and his first relationship is with the person who feeds him. Therefore, a baby's need for food is satisfied by the emotionally secure mother who is able to be flexible about a feeding schedule. Even when unable to breast feed her baby, such a mother can hold and cuddle the child while he is bottle fed. A satisfactory relationship established at this time tends to extend into other life situations.

Tensions arising between mother and child about feeding matters contribute to strained relationships about other matters such as cleanliness and sleep. These tensions initiate negative behavior such as thumb sucking, enuresis, temper tantrums, speech disorders, constipation, psychogenic vomiting, and nail biting. Early hostilities and resentments are aroused also by the mother who adheres to a rigid, inflexible feeding schedule, withholds food and thereby initiates the anticipation of other frustrations. The child's emotional reactions are easily related to the objects and things that become identified with fear, rage, or hostility and extend into phobias and night terrors.

Neurotic patterns evolve by a child's refusing to take food. A child deprived of warmth and affection uses this mode of self-thwarting to hurt the mother and to get more of her concern. Another tension area arises over the necessity to toilet train a child. Sphincter control is best established as a learning process when the child is able to verbalize its needs. Rigid habit training fosters the formation of a child's later attitudes towards discipline and contributes to compulsions, chorea, asocial behavior, and school difficulties.

The emotionally secure mother presents a consistent front and her loving warmth is an expression of her mature desire to protect her child. The insecure mother exploits or smothers her child; she can be either overconcerned or indifferent. A sense of undue responsibility drives her to do what she feels morally obligated to do without the natural acceptance of what is good for the child and herself. A satisfactory balance between the need for self-expression and self-repression can be identified in spontaneous rather than automatic reactions with available energy for constructive purposes. Overprotected children are emotionally handicapped by parents who are dependent upon them and smother them with attention; the child is used as a substitute for an unsatisfactory marriage relationship or some other personal lack.

Dynamics of Adjustment

Inevitable conflicts arise throughout life in expressing our needs for self-esteem, self-preservation and self-projection. Tensions which originate in these conflicts are reduced or resolved by compromise solutions called adjustment or mental dynamisms. Some of the common mechanisms will be discussed next month.

THE BOOK SHELF

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SURVEY OF CLINICAL PEDIATRICS, Third Edition, by Lawrence B. Slobody, M.D., Professor of Pediatrics, New York Medical College; Director of Pediatrics, Flower and Fifth Avenue Hospitals, Metropolitan Hospital; Medical Director, Children's Center, New York City. New York: McGraw-Hill Book Company, Inc., The Blakiston Division, 1959. 556 pp. Price $11.00.

This third edition of *Survey of Clinical Pediatrics* reflects the growth and changing practices—the vast progress—that have been made in the area of pediatrics since its predecessor appeared in 1955. It is concise in its coverage of the clinical manifestations of illness. The treatment of topics is organized in a modified outline form, except where detailed discussion is essential for understanding the disease or condition. This is particularly obvious in the discussion of anemias, genitourinary diseases, and heart diseases.

There are twenty-three chapters, namely: (1) Growth and Development, (2) Feeding of Infants and Children, (3) Vitamins and Metabolism, (4) Preventive Pediatrics, (5) Psychologic Problems, (6) Treatment, (7) Fluid and Electrolyte Balance, (8) The Normal Newborn Infant, (10) Prematurity, (11) Infectious Diseases, (12) Respiratory Diseases, (13) Heart Disease, (14) Gastrointestinal Diseases, (15) Surgical Conditions of the Abdomen, (16) Genitourinary Diseases, (17) Neurologic Conditions, (18) Diseases of the Skeletal System, (19) Blood Disorders, (20) Neoplasms of Infancy and Childhood, (21) Endocrine Diseases, (22) Allergy, (23) Skin Disorders.

There are review questions at the end and an outline in the appendix for taking a patient's history and for recording the findings of the physical examination.

This is a suitable text for medical students, as well as a quick orientation for the private practitioner of medicine. Nurses working on pediatrics will welcome this book as a helpful reference.

PATTERNS OF PROFESSIONAL EDUCATION by William J. McGlothlin, Vice-President, University of Louisville. New York: G. P. Putnam's Sons, 1960. 228 pp. Price $6.75.

Throughout the field of professional education, educators have realized for some time, the need to explore and to examine critically the structure and the process by which the professions prepare persons for careers. In this comparative study of ten professions, the author identifies the problems and suggests a reappraisal of educational programs. This book does what it claims—analyzes the aims of professional education, the curriculums, the methods of instruction, the faculty, recruitment and selection of students, the relations between the professional schools and the universities, accrediting, instruction in professional ethics. Suggestions for improvement are offered.

Criticism of education for the professions has been vocal, but not always objective. This has been true particularly where professional schools have functioned apart from universities and educational institutions. While education for each profession is different, the aims and objectives are similar, namely: to provide a broad educational base and professional competence. The author points out that the professions are handicapped when projecting plans for expansion. The social needs are frequently not well-defined, and there are gaps between what is in the literature and what is proposed. There are conflicts in administrative relationships between the professional school and the university. The status and acceptance of the professional school within the university, and its recognition by the public, influence recruitment of students and also financial support.

In his conclusion, the author suggests that a National Conference of professional schools be created to exchange ideas about curriculums, methods of instruction, and for discussion of mutual problems. Data on costs of professional versus liberal arts education are not available until further studies are made.

Since nursing is one of the professions analyzed, it should be encouraging to note that all professions have experienced difficulties when they have moved from apprenticeship to a university program. As is true in other professions, nursing is constantly evaluating its educational programs to improve professional practice.

This book should be helpful to all educators since it discusses, in practical terms, the organization and conduct of professional education.

AIDS TO BACTERIOLOGY FOR NURSES by E. Joan Bocock, S.R.N., S.C.M., D.N. (London), Principal Tutor at the Royal Free Hospital, London; and Katharine F. Armstron, S.R.N., S.C.M., D.N. (London), Formerly Sister Tutor at King's College Hospital, London, and Editor of the *Nursing Times*, with the assistance of the Medical Staff of the Bacteriology Department of the Royal Free Hospital, London. Baltimore, Maryland: The Williams & Wilkins Company, 1959. 175 pp. Price $3.00.

Aids to Bacteriology for Nurses is a pocket-size volume related to the study of bacteriology and the application of its principles to the practice of nursing. It is one of a series of handbooks to provide concise and complete information in different fields of knowledge that can be read easily and carried in the student's pocket.

The changing course of many infectious diseases, newer methods of treatment, and consequent modifications in control make it necessary for the nurse to have a thorough understanding of bacteriology. Although the material of this book is elementary, the essential facts are fully covered. This makes it easy for the student to remember the essential points stressed.

In the ten chapters, a clear-cut description of the following topics is presented: (1) Introduction: Why Bacteriology, (2) Bacteria and Other Microorganisms, (3) The History of Bacteriology, (4) Infection and Immunity, (5) The Microscope, (6) Diagnostic Bacteriology and Practical Demonstrations, (7) Normal Flora of the Human Body, (8) A Guide to Common Pathogenic Organisms, (9) Bactericides, (10) Bacteriology Applied to Nursing Procedures. There are two Appendixes. Appendix I presents

XUM

the "Common Pathogenic Bacteria." Appendix II considers "The Protection of the Nurse."

In the final chapter, some of the nursing procedures discussed have been abandoned in this country: namely, the soaking soiled linen in lysol or White Cyllin and disinfection of excreta and sputum.

NURSING WORLD Reports

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the course will be Occupational Health Nursing as viewed by management, the Physician and the Nurse, The Small Plant Problem, Labor Relations, and Counselling and Interviewing Technics. Applicants should contact the Dean, NYU Post-Graduate Medical School, 550 First Avenue, New York 16, New York. Tuition is $60; the course number is 484.

Visiting Dignitary

Greek Nurse in U.S.—Lieutenant Colonel Cleopatra Avayanou, head of the Queen Frederika Military Nursing School and general chief nurse of the Nurse Corps, is in the United States to study all phases of nursing activities from recruitment to nursing requirements for disaster planning. Colonel Avanayou has served in her country's nursing corps for 27 years, since its inception. In her U.S. tour she has observed nursing personnel from California to New York.

Recent Elections

Zonta Club—Mrs. Anne Zimmerman, executive director of the Illinois Nurses' Association, was elected president of the Evanston Zonta Club. Mrs. Zimmerman is also chairman of the Economic and General Welfare Committee of the American Nurses' Association.

New Club President—Dorothy E. Brake, director of the Department of Nursing at St. Barnabas Medical Center in Newark, New Jersey, has been elected president of the Soroptimist Club of Newark. Miss Blake is the former director of nurses and principal of the School of Nursing at Norwegian Lutheran Hospital in New York.

New Officers for AIN—The Greater New York Association of Industrial Nurses, Inc., elected the following officers at its annual business meeting: Anita M. Harris, R.N., president; Marion M. Doyle, R.N., 1st vice president; Florence Delabar, R.N., 2nd vice president; Ruth Hanchey, R.N., treasurer.

Appointments

Editorial Appointment—Miss Marjorie L. Wenger has been appointed editor of the International Nursing Review, spokesman publication for the International Council of Nurses. Miss Wenger has been editor of the *Nursing Times,* journal of the Royal College of Nursing in London, England, for the past twelve years. In that capacity she has become familiar with international nursing developments; she has attended such functions as the World Health Assembly in Geneva and the 50th anniversary Convention of the Canadian Nurses' Association. As a nurse journalist Miss Wenger has probed deeply into health conditions throughout the British Isles.

Nursing As Others See It

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shoeless Steve on his back. Campers teamed up to clear the boulder-strewn road above the camping grounds so that cars could move the injured."

Fifteen Critically Injured

At the ridge, Mrs. Greene went to work nursing the wounded. There were at least fifteen critically hurt, some with severe body wounds, internal injuries, fractures and deep lacerations. She bandaged one woman with bath towels and had her placed on an air mattress in the rear of the station wagon. Concerned about possible infection, Nurse Greene improvised ice packs by securing ice from camping kits and tearing the plastic cover from a trailer.

The article cites this valiant woman's efforts in boosting the morale of the campers as she encouraged them throughout the night, confident that help would come by daylight. At eight thirty the next morning, Dr. Raymond G. Bayles and Nurse Jane Winton appeared, supplied with antibiotics and morphine. Before noon, a U.S. Air Force helicopter was on the scene, and by three o'clock, rescue work was completed.

Dr. Bayles later commented that many of the injured owed their lives to the care provided by Nurse Greene. "She had done wonderful work," he said. "When I arrived, she had the most severely injured grouped together so that I could treat them without delay. . . Several of the injuries could have been fatal if mishandled or not treated. . ."

Mildred Greene's performance was highly commended. From the Billings Deaconess Hospital Board came this fitting tribute: "The courage and skill you demonstrated exemplify the highest attributes of nursing."

Advances and Trends . . .

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There is danger of increasing peripheral edema and ascites however.

Arginine Hydrochloride—This drug has been used to stimulate the formation of urea from ammonia. Limited experiences have not been encouraging and failure has been attributed to the fact that urea production is also limited by the availability of bicarbonate. Since the latter is decreased in hepatic coma, it may be that improved results could be obtained with the addition of bicarbonate. Arginine glutamate, which is said to have the advantage of being sodium free, has also been unimpressive in hepatic coma.

Adrenal Steroids—The use of adrenal steroids in hepatic coma associated with cirrhosis has not met with uniform success. Response may temporarily be dramatic but death may result subsequently even from resulting bleeding gastric ulcers. In fulminant hepatitis with coma, large doses of steroids are indicated.

Control of Gastrointestinal Bleeding—The control of gastrointestinal bleeding is essential in hepatic coma, not only from the hemohepatic dynamic point of view, but also because blood represents a heavy protein meal. Bleeding from esophageal varices can be controlled either with a Sengstaken-Blakemore tube or possibly with Pitressin. After bleeding has subsided the patient must be given regular antacid therapy to prevent erosion of varices by the regurgitation of acid from the stomach.

Administration of Medications—Since these patients are comatose, the nurse frequently asks the question as to whether or not oral medications should be forced on these patients. The use of a Levine Tube which goes through the cardiac sphincter causes the unnecessary hazard of regurgitation and consequent aspiration. The irritation of such a tube increases nasopharyngeal secretions which are poorly handled by the comatosed patient and there is also the hazard of rupturing esophageal varices. Perhaps the best compromise is the intermittent use of the short nasal feeding tube, using great care not to give too much at a time and to tilt the patient up during feeding and for 30 minutes after.

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PEDIATRIC INSTRUCTOR to teach in clinical area. Two pediatric instructors in Department. There are 25 full time nurse instructors. Sciences are taught by Albright College. School being enlarged and size of faculty increased. School has full accreditation by N.L.N. with no recruitment problem. Hospital has 575 beds and is in an expansion program. An entirely new pediatric department will be in the new building starting in Fall. Salary $4740 with increases to $5340. Starting salary $4980 for qualified instructor with two years teaching experience. Retirement plan in addition to Social Security, Hospital pays 5% of salary into fund and employee pays 3%. After 5 years Hospital provides a life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in the nurses residence has its own private bath and shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city. Four universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in Nursing Education. Apply: Director of Nurses, The Reading Hospital, Reading, Pa.

PSYCHIATRIC NURSES — Rewarding careers for both men and women as professional nurses in nation's largest Federal mental hospital. Progressive teaching program and opportunities for participation in National Institutes of Health research projects. Beautiful hospital grounds in residential section near U.S. Capitol. Several near-by universities offer opportunities for advanced education. Positions are for Staff, Head and Supervisory Nurses in career civil service with the Department of Health, Education, and Welfare. Annual salaries range from $4040 to $8230, depending upon education, experience and prior Federal Service. Liberal fringe benefits include group health and life insurance, retirement benefits, generous vacation and sick leave. Write Director of Nurses, Office W. Saint Elizabeths Hospital, Washington, D.C.

OBSTETRICAL SUPERVISOR Responsible for the administration of a 53-bed obstetrical unit consisting of a delivery room and two floors. Present hospital has 575 beds. Starting a $2,500-000 building in the Fall which will house an entirely new obstetrical unit. Department has full time obstetrical instructor. Large school with no recruitment problem. Salary $4740 with six month increases to $5340. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund and employee 3%. After 5 years of service, Hospital provides a life insurance policy for the employee equivalent to a year's salary. Hospital pays the policy. Other liberal personnel policies and attractive living and teaching facilities. Each room in the residence has its own bath and shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city. Four universities have extension center or extension courses in the city. Qualifications: Baccalaureate Degree and past supervisory experience. Apply: Director of Nurses, The Reading Hospital, Reading, Pa.

OBSTETRICAL INSTRUCTOR no administrative responsibilities. Department has Obstetrical Supervisor to assist with clinical teaching. School is being enlarged and size of Faculty increased. Full accreditation from N.L.N. Large school with no recruitment problem. 25 full time nurse instructors. Sciences taught by Albright College. Hospital now has 575 beds and is in an expansion program. Entirely new obstetrical department in new building to be started in Fall. Salary $4740 with increases to $5340. Starting salary $4980 for qualified instructor with two years teaching experience. Retirement plan in addition to Social Security, Hospital pays 5% of Salary into fund and employee pays 3%. After 5 years, Hospital provides a life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses residence has its own private bath and shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city. 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with Courses in Nursing Education. Apply: Director of Nurses, The Reading Hospital, Reading, Pa.

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Advances and Trends . . .

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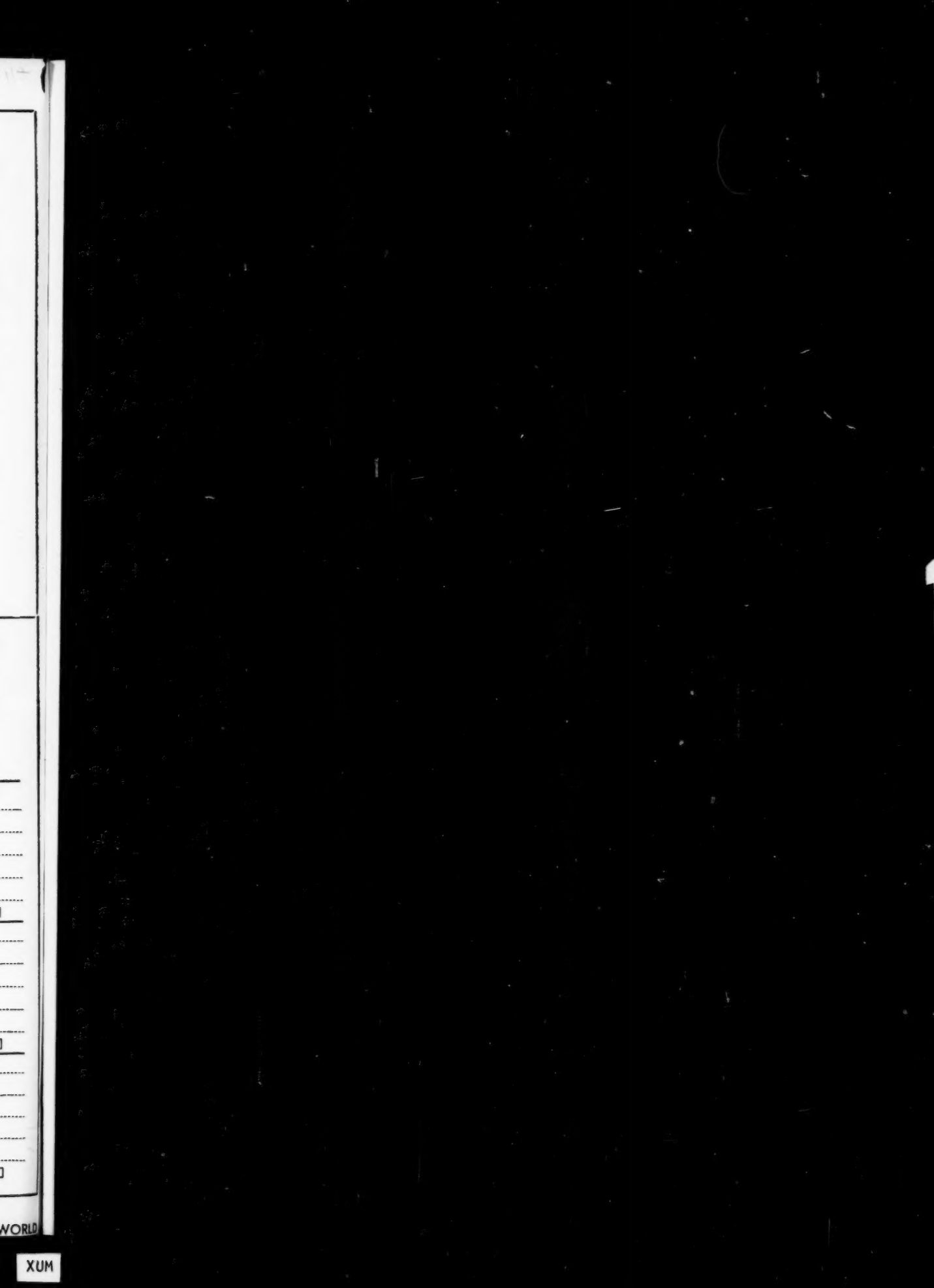
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